

9397

Item 11 Film G188 11-10-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 38

379

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lutherville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Balto. City 3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>				STREET ADDRESS (If rural, give location) <u>Green Mount Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna Schultz Alexander</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 31 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>May 13, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Physician</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Medicine</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wm. S. Schultz</u>				14. MOTHER'S MAIDEN NAME: <u>Louise Tolman (?)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Dr. Ronald S. Alexander - 10660 Kinn. Pk.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary embolus</u>						<u>minutes</u>	
ANTECEDENT CAUSE (B) <u>Thrombophlebitis of legs</u>						<u>one mon</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral arteriosclerosis</u>						<u> yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March, 1955</u> to <u>present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/27</u> , 19 <u>55</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emmet C. Brown Jr.</u>		M. D. <u>1161 N. Calvert St</u>		DATE SIGNED <u>11/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Nov 12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/1/55</u>		REGISTRAR'S SIGNATURE <u>G.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Stewart J. Mowbray Co.</u>		ADDRESS <u>139116 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DECLARATION OF DEATH

1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Signature of declarant: _____

6. Signature of witness: _____

7. Signature of physician: _____

8. Signature of coroner: _____

9. Signature of registrar: _____

10. Signature of clerk: _____

11. Signature of judge: _____

12. Signature of jury: _____

13. Signature of jury: _____

14. Signature of jury: _____

15. Signature of jury: _____

16. Signature of jury: _____

17. Signature of jury: _____

18. Signature of jury: _____

19. Signature of jury: _____

20. Signature of jury: _____

21. Signature of jury: _____

22. Signature of jury: _____

23. Signature of jury: _____

24. Signature of jury: _____

25. Signature of jury: _____

26. Signature of jury: _____

27. Signature of jury: _____

28. Signature of jury: _____

29. Signature of jury: _____

30. Signature of jury: _____

9298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 <u>Catonsville</u>		<u>1 yr. 7 mos. 2 wks.</u>		<u>Sparrows Point</u> x			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 <u>Spring Grove State Hosp.</u>				<u>212 E. Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>G. Sherman</u>				<u>Adams</u> <u>10-24-1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>M</u>	<u>11-13-1873</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>COAL & SCRAP STEEL</u>		<u>Ky.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Randal Adams</u>				<u>Polly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service:				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>402-01-1653</u>		<u>Hospital records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
420.0						18 mos.	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						5+ yrs.	
(A) <u>Arteriosclerotic Heart Disease</u>							
DUE TO							
(B) <u>Generalized Arteriosclerosis</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 11</u> , 19 <u>54</u> , to <u>Oct. 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 24</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Louise Frances Woodward</u>				<u>M. D. Spring Grove State Hosp. Catonsville 28, Md.</u>		<u>10-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-28-55</u>		<u>BELAIR MEMORIAL</u>		<u>BELAIR, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 28, 1955</u>		<u>Victor E. Harry</u>		<u>Walter Burke Bradley, Hurdell, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

RECEIVED
NOV 1 1955
BUREAU V. B.

9399

09381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 46

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN</u> <u>Dundalk, Turner's Station</u>			
HOSPITAL, OR INSTITUTION OR STREET ADDRESS <u>Pulaski Hgwy. near Middle River</u>				STREET ADDRESS (If rural, give location) <u>129 Main Street</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u>		(Middle) <u>I.</u>		(Last) <u>ADAMS</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>15</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 27, 1915</u>		9. AGE last birthday: <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Night Club</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Iwin Adams</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Rosa Adams, 123 Main Street</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>983X</u> Immediate cause (a) <u>Asphyxiation</u> DUE TO Antecedent cause(s) (b) <u>strangulation</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>field</u>		21c. (City or town) <u>Pulaski Hgwy. near Middle River Road</u> (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10/15/55 3:15 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Strangled with rope.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William J. [Signature]</u>		M. D. <u>10/16/55</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		LOCATION (City, town, or county) (State) <u>Baltimore. Maryland</u>	
DATE REC'D BY LOCAL REG. <u>10/19/55</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		24. FUNERAL DIRECTOR <u>Elroy O. Wilson, 2004 Orleans Street</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

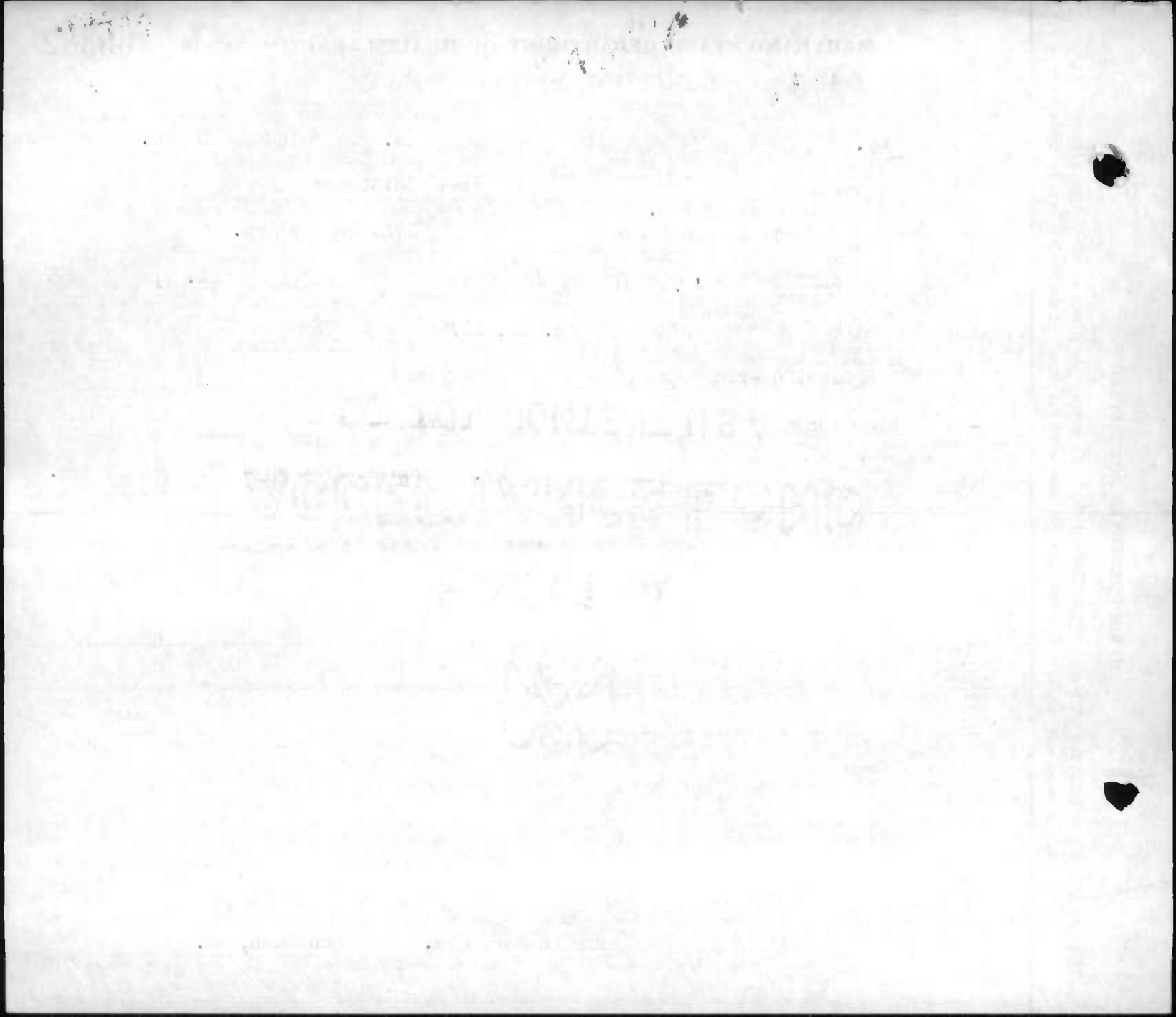
BUREAU V. S.

OCT 25 1965

RECEIVED

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



09383

STATE DEPARTMENT OF HEALTH

MARYLAND

9411

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13, 14 Film G188 10-25-55 et

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Overlea		CITY (If outside corporate limits, write RURAL and give nearest town) Overlea	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4209 Thorncliff Road		STREET ADDRESS (If rural, give location) 4209 Thorncliff Road #6	
3. NAME OF DECEASED (Type or Print) Mr. Daniel H. Alley Sr.		4. DATE OF DEATH (Month) (Day) (Year) Oct. 17th 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH June 16, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker Ret.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 77 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 216-18-0918	
17. INFORMANT AND ADDRESS Mr. Daniel H. Alley, Jr. 4209 Thorncliff Rd			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause		heart failure	3 yrs
Antecedent cause(s)		chron. myocarditis	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			

II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct 16, 1955 to Oct 17, 1955, that I last saw the deceased alive on Oct 16, 1955, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

SIGNATURE [Signature]		ADDRESS DR. RICHARD R. RIGLER		DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 19, 1955	NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	LOCATION (City, town, or county) Baltimore, Maryland	(State)
DATE REC'D BY LOCAL REG. 10/18/55	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14	ADDRESS	

MARGIN RESERVED FOR BINDING

1

Dr. Rigler
1 W. Overlea Ave.
9 - 11 A.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9387

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09384
Reg. Dist.

No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Fansdown</u>				TOWN <u>Fansdown</u>		51	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1932 Sulfur Springs Rd</u>				STREET ADDRESS (If rural, give location) <u>1932 Sulfur Springs Rd</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>Ammond</u> (Last) <u>Ammond</u>				(Month) <u>Oct</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>April 3 1888</u>	
9. AGE last birthday: <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>Ammond</u>			
14. MOTHER'S MAIDEN NAME: <u>Ammond</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			
16. SOCIAL SECURITY No.: <u>212 05-2239</u>				17. INFORMANT & ADDRESS: <u>Augusta E Ammond Sulfur Springs Rd 1932</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary thrombosis</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Der M Kieffer</u>				1010 Leaden			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>10-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
LOCATION (City, town, or county) <u>Balto md</u>				(State)			
DATE REC'D BY LOCAL REG <u>Oct 27 55</u>		REGISTRAR'S SIGNATURE <u>Der Kieffer</u>		24. FUNERAL DIRECTOR <u>Donald H Hubert</u>		ADDRESS <u>Fansdown</u>	

Mr J. M. Brown
Washington
11-30 PM

RECEIVED
OCT 31 1963
BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

9374

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>	
TOWN <u>DUNDALK</u>		TOWN <u>DUNDALK (22)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 NORTHSHIP RD</u>		STREET ADDRESS (If rural, give location) <u>47 NORTHSHIP RD</u>	
3. NAME OF DECEASED (Type or Print) <u>ABRAHAM</u> (First) <u>GOOD</u> (Middle) <u>BACHMAN</u> (Last)		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 10, 1873</u>
9. AGE last birthday <u>82</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		12. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
13. FATHER'S NAME <u>ABRAHAM M. BACHMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARIA GOOD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>181-05-1813</u>	
17. INFORMANT <u>HELEN W. BACHMAN - WIDOW</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Chronic Myocarditis

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William M. Kelly Dep. Med. Exam. - Dundalk - 22. Md. 10/19/55

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL10-20-55MEADOWRIDGEHOWARD CO. MD.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct 19-1955William M. KellyWalter R. Kelly, Dundalk, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

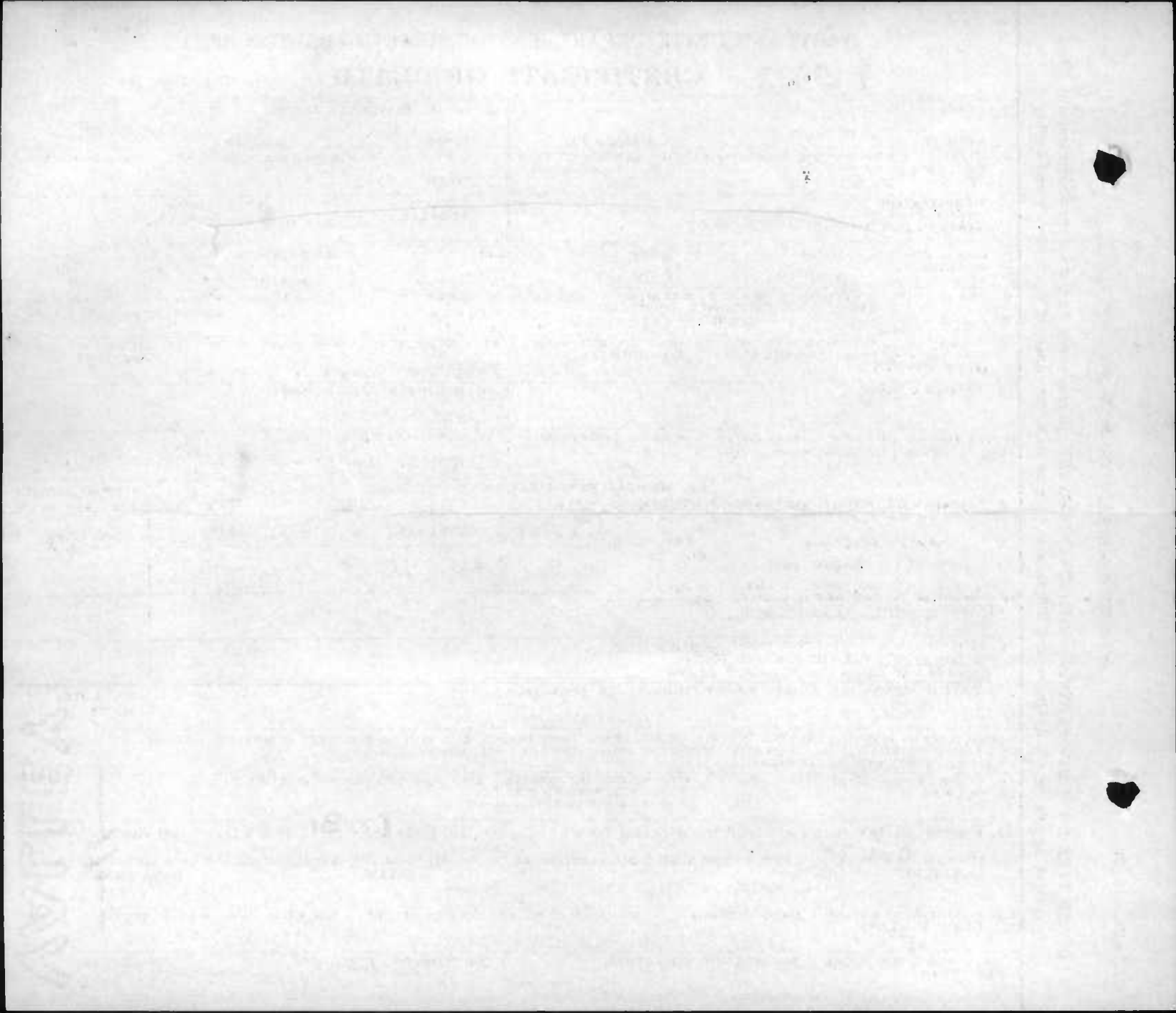
09386

9492

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2802 Lingmore Ave.</u>				STREET ADDRESS (If rural give location) <u>2802 Lingmore Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Ada Rebecca Baker</u>				OF DEATH: <u>Oct. 31 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Nov. 15, 1879</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				Months	Days	Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At home</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore Co., Md.</u>	
13. FATHER'S NAME: <u>Benjamin F. Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Almira Krout</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Gladys A. Rosier - 2802 Lingmore Ave.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A) <u>Carelessness of the breast</u>				<u>6 yrs</u>
ANTECEDENT CAUSE (S)			DUE TO <u>with gen. metastases</u>				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			(B) DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Oct 10, 1955</u> , to <u>Oct 31, 1955</u> , that I last saw the deceased alive on <u>Oct 24, 1955</u> , and that death occurred at <u>230 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>			ADDRESS <u>7122 Surprenant Rd</u>			DATE SIGNED <u>11/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>11/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>11/2/55</u>			REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Ellsworth Armacost - 4600 Liberty Heights Ave. 7</u>		



9473

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55 TOWSON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>55 TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>506 Fairmount Ave.</u>		STREET ADDRESS (If rural give location) <u>506 Fairmount Ave.</u>	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mae Elizabeth Baker</u>		OF DEATH: <u>Oct. 10, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>May 9, 1870</u>
9. AGE last birthday <u>85</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Joseph Stewart</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Harry Baker</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Almonage of Intestine</u>		
ANTECEDENT CAUSE (S) DUE TO (B) <u>Ascending Colon from Cancer</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>of Ascending Colon</u>		<u>3 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1955, to Oct, 1955, that I last saw the deceased alive on Oct 10, 1955, and that death occurred at 9⁰⁰ M, from the causes and on the date stated above.

SIGNATURE <u>Charles F. McDonnell</u>		ADDRESS <u>750 York Rd Towson Md</u>		DATE SIGNED <u>10/11/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>Oct. 12, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Co., Md.</u>	(State)
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 12, 1955</u>	REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	24. FUNERAL DIRECTOR <u>John Burnie Sons, Towson, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VI 8

1955 13 13

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 30

9404

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 House in Pines 16 Lusting Ave</u>		STREET ADDRESS (If rural give location) <u>512 Charingwood Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>James L. Ball</u>		<u>Oct. 14 1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>June 23/64</u>
9. AGE last birthday <u>91</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Ind.</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Stephen Ball</u>		14. MOTHER'S MAIDEN NAME: <u>Ann Heacon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>512 Charingwood Rd</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			<u>1 da.</u>
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 26, 1955</u> to <u>Oct. 14, 1955</u> , that I last saw the deceased alive on <u>10-14</u> , 1955, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William K. Gallagher</u>		DATE SIGNED <u>10-16-55</u>	
ADDRESS <u>M. D. Catonsville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/17/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 19 1955

BUREAU V. B.

9495

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>	
X TOWN <u>Lutherville</u>		STREET ADDRESS (If rural give location) <u>20-40-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>LAURA BARTLETT</u>		<u>October 29 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>August 7, 1869</u>
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Richard Frempton</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Rigby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>			<u>3 weeks</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Fall of 1954</u> , to <u>present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 29</u> , 19 <u>55</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ernest C. Brown Jr.</u>		ADDRESS <u>1101 N. Calvert St Baltimore</u>	
DATE SIGNED <u>Oct. 30, 1955</u>		M.D. <u>1101 N. Calvert St Baltimore</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 31, 55</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

BUREAU VI. 81

NOV 1 1955

RECEIVED

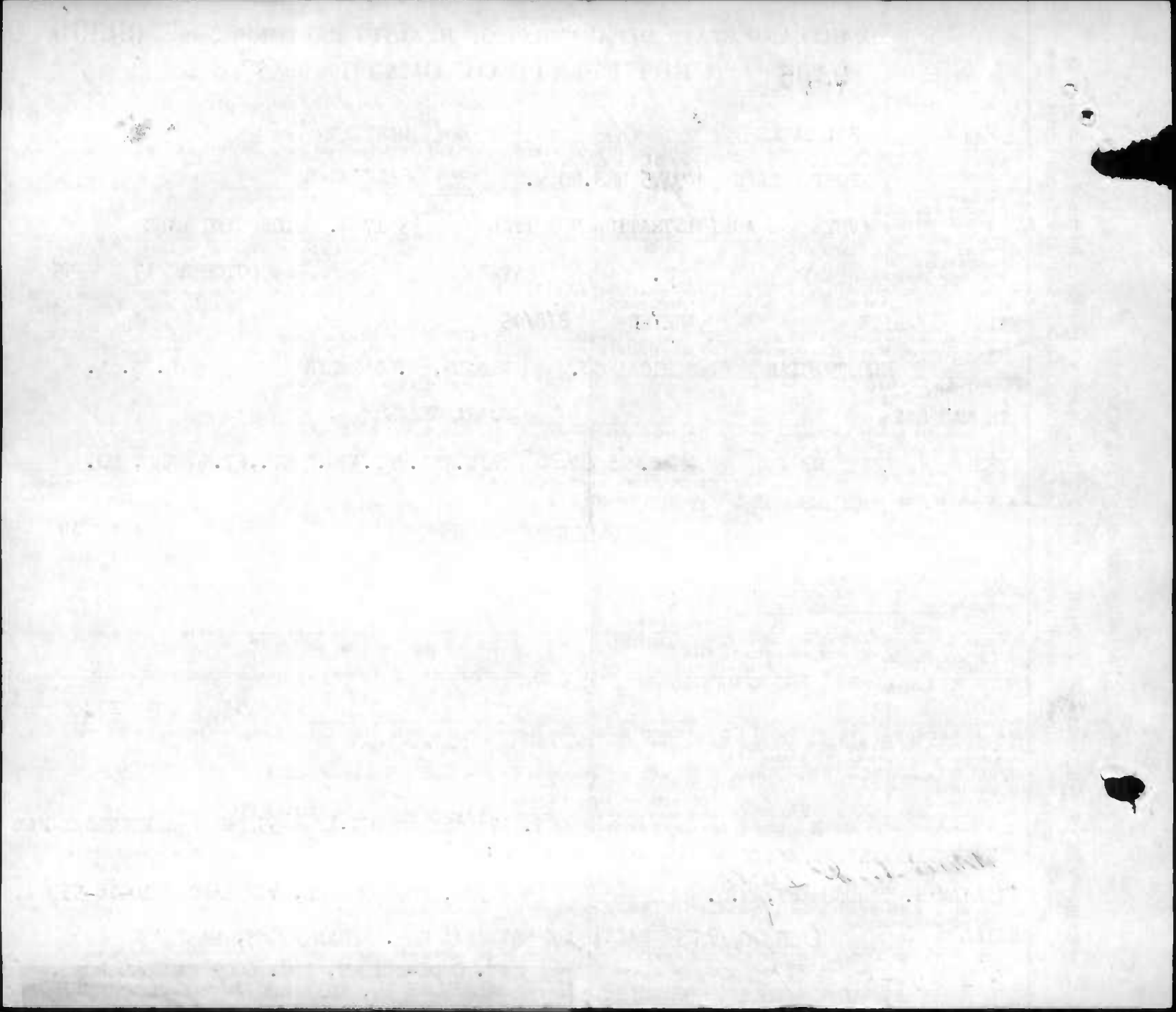
9406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 5 HRS. 40 M.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 3817 W. COLDSRING LANE			
3. NAME OF DECEASED: (First) (Middle) (Last) HENRY B. BATES				4. DATE (Month) (Day) (Year) OF DEATH: OCTOBER 17 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 8/8/95	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN				10B. KIND OF BUSINESS OR INDUSTRY: ELECTRICAL CO.		11. BIRTHPLACE (State or foreign country): ARNOLD, N. CAROLINA	
13. FATHER'S NAME: THOMAS BATES				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES WW I				16. SOCIAL SECURITY NO. 220-03-6435		17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) RIGHT CEREBRAL HEMORRHAGE						UNKNOWN	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? 6:00 PM			
22. I hereby certify that I attended the deceased from OCT. 17, 1955 to OCT. 17, 1955 , and that death occurred at 6:00 M. from the causes and on the date stated above. SIGNATURE WILLIAM B. VANDEGRAFT, M.D. ADDRESS M. D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 10-18-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF OCT 20, 1955		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-19-55		REGISTRAR'S SIGNATURE W. B. Vandegraft		24. FUNERAL DIRECTOR ADDRESS WM. COOK-BLIGHT, INC. 6009 HARFORD ROAD, BALTIMORE 14, MARYLAND			

MARGIN RESERVED FOR BINDING



9338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>51 Halethorpe</i>	LENGTH OF STAY (in this place) <i>8 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>51 Halethorpe</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1801 Woodside Ave</i>		STREET ADDRESS (If rural give location) <i>1801 Woodside Ave</i>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <i>Samuel</i>	(Middle) <i>Silden</i>	(Last) <i>Baumbly</i>	<i>Oct 12 1955</i>
5. SEX: <i>M</i>		6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married January 8, 1877</i>
8. DATE OF BIRTH: <i>78 yrs.</i>		9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>U S Navy Yard</i>	11. BIRTHPLACE (State or foreign country): <i>Beckleyville Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME: <i>John Baumbly</i>	
14. MOTHER'S MAIDEN NAME: <i>Sarah Mally Martyn</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218-16-2081</i>		17. INFORMANT & ADDRESS: <i>Mrs Clara A. Baumbly Halethorpe Md.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>420.1</i>		
ANTECEDENT CAUSE (S) <i>Coronary Occlusion see.</i>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) <i>to A. S. C. V. D.</i>		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9/15, 1955*, to *10/12, 1955* that I last saw the deceased alive on *10/12*, 1955, and that death occurred at *8:00 P.M.* from the causes and on the date stated above.

SIGNATURE <i>John C. Stealy</i>	M.D.	ADDRESS <i>Baltimore Md</i>	DATE SIGNED <i>10/14/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>10/15/55</i>	NAME OF CEMETERY OR CREMATORY <i>Long Hill Cemetery</i>	LOCATION (City, town, or county) (State) <i>Lanesh Maryland</i>
DATE REC'D BY LOCAL REGISTRAR <i>Oct 15-55</i>	REGISTRAR'S SIGNATURE <i>Leo S. M. Shiffers</i>	24. FUNERAL DIRECTOR <i>Willie Donaldson</i>	ADDRESS <i>Lanesh Md</i>

MARGIN RESERVED FOR BINDING

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

CROSS COUNTRY

WINTER

BUREAU V. S.

OCT 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **09392**
9407 CERTIFICATE OF DEATH

Reg. Dist. No. **33**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Pikesville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 508 Sudbrook Rd.				STREET ADDRESS (If rural give location) 508 Sudbrook Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES H. BAUER, Sr.				4. DATE (Month) (Day) (Year) OF DEATH: Oct. 20, 19 55			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Feb. 3, 1870	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Dairyman		10B. KIND OF BUSINESS OR INDUSTRY: Self Employed		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Joseph Bauer				14. MOTHER'S MAIDEN NAME: Mary Elizabeth Bergen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: no		17. INFORMANT & ADDRESS: Pikesville Mrs. Johanna Bauer - 508 Sudbrook Rd.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 493X Pneumonia						1 week	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Abdominal Tumor							
19A. DATE OF OPERATION: —				19B. MAJOR FINDINGS OF OPERATION: —			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 10, 1955 , to Oct. 20, 1955 , that I last saw the deceased alive on Oct 19, 1955 , and that death occurred at 3 1/2 M. from the causes and on the date stated above.							
SIGNATURE Howie Salzman		M. D. Pikesville 8, Md		DATE SIGNED 10/21/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/22/55		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE REC'D BY LOCAL REGISTRAR 10-27-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Wm. J. Tiekner & Sons - Balto 17, Md.		ADDRESS	

MAINTENANCE AND REPAIRS OF BUILDINGS
UNITED STATES OF AMERICA
OFFICE OF THE DISTRICT ATTORNEY
WASHINGTON, D. C.

TO THE HONORABLE THE DISTRICT ATTORNEY
WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above captioned matter.

I am sorry to hear that you are unable to locate the person or persons who are responsible for the damage to the building.

I am sure that you will continue to make every effort to locate them.

I am, Sir, very respectfully,
Yours truly,
[Signature]

RECEIVED
DISTRICT ATTORNEY
WASHINGTON, D. C.
JAN 11 1911

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09393

9498

CERTIFICATE OF DEATH

Item 12, Film G188 11-3-55 et

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>		52	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>635 North Bend Road</u>				<u>635 North Bend Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>Bauer</u> (Last) <u></u>				(Month) <u>Oct.</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Feb. 19, 1875</u>	<u>82</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Proprietor of Grocery Store</u>		<u></u>		<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>----Bauer</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<u>(Daughter)</u> <u>Mrs. John Staib, 3612 Elkador Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Anterior infarct of the heart</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>various diseases</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/11/55</u> , 19 <u>55</u> , to <u>10/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/18</u> , 19 <u>55</u> , and that death occurred at <u>9:10</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William M. D. 1031 Willow Crest</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 29/55</u>		<u>New Cathedral</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct. 29, 1955</u>		<u>Victor E. Darrys</u>		<u>Harry H. Witzke</u>		<u>4101 Edmondson Ave.</u>	

OREAD V.

OCT 28 1955

9479

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY BALTO.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN ESSEX

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

803 PLATUIM AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MO. COUNTY BALTO

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN ESSEX

STREET ADDRESS (If rural, give location)

803 PLATUIM AVE

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ELIZABETH M BEARMAN

4. DATE (Month) (Day) (Year)

OF DEATH: OCT. 18 19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

RUFUS K BEARMANSAME AS ABOVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 7, 1954, to Oct 18, 1955, that I last saw the deceased alive on Oct 18, 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

3479 Lib. Parkway.

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09395

9410 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FORT HOWARD</u>		<u>8 hrs. 55 mins.</u>		TOWN <u>BALTIMORE</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>VETERANS ADMINISTRATION HOSPITAL</u>				<u>8708 WISE AVENUE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)				
<u>EDWARD</u> (NMT) <u>BERNICK</u>			DEATH: <u>OCTOBER 16</u> 19 <u>55</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>12/24/86</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>MINER</u>			<u>COAL MINES</u>		<u>SHENANDOAH, PENNSYLVANIA</u>		<u>U.S.A.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JOHN BERNICK</u>				<u>JULIA RECTOR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
<u>YES</u> <u>WWI</u>			<u>179-09-7580</u>		<u>CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>OLD AND RECENT INFARCTS OF THE HEART</u>							<u>UNKNOWN</u>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT. 16, 1955</u> , to <u>OCT. 16, 1955</u> , that I last saw the deceased <u>12:35 PM</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>				ADDRESS <u>M.D. VAN FORT HOWARD, MARYLAND</u>			
DATE SIGNED <u>10/17/55</u>							
23. REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Oct 19 1955</u>		<u>SACRED HEART CEMETERY</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-18-55</u>		<u>Wm. Cook Blight</u>		<u>WM. COOK BLIGHT INC. FUNERAL HOME</u>		<u>6009 HATFORD RD., BALTIMORE 14, MARYLAND</u>	

UNITED STATES OF AMERICA

THE UNITED STATES OF AMERICA
DO hereby certify that
[Name] [Address]
[City] [State] [County]
[Country]
[Date]

9411

CERTIFICATE OF DEATH

Reg. Dist. No.

093962

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6802 Navajo Drive</u>		STREET ADDRESS (If rural give location) <u>6802 Navajo Drive</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Jacques</u>	(Middle) <u>B</u>	(Last) <u>Bernstein</u>	(Month) <u>10</u> (Day) <u>14</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH:
			9. AGE last birthday <u>38</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman liquor</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Jerome B. Bernstein</u>		14. MOTHER'S MAIDEN NAME: <u>Susan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hilda Bernstein - same</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>420.1 CORONARY INFARCTION</u>		<u>12 hours</u>
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>July 9, 1950</u> , to <u>October 19, 1955</u> , that I last saw the deceased alive on <u>Sept 10, 1955</u> , and that death occurred at <u>6:39 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Melvin N. Borden</u>		ADDRESS <u>5000 Old Frederick Rd</u> DATE SIGNED <u>10/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>10-16-55</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>Oct 15 1955</u>	REGISTRAR'S SIGNATURE <u>Anthony Howell</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Jack Lewis Inc 2100 Eutaw Pl</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

OCT 19 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09397

9412

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BALTIMORE CITY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HOUSE IN THE PINES 16 FUSTING AVE		STREET ADDRESS (If rural, give location) 3603 GLEN AVE.	
3. NAME OF DECEASED (Type or Print)	(First) JOSEPH	(Middle)	(Last) BERNSTEIN
4. DATE OF DEATH	(Month) 10	(Day) 22	(Year) 1955
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH
			9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPTOMETRIST		10b. KIND OF BUSINESS OR INDUSTRY OPTICAL	
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME HARRY BERNSTEIN		14. MOTHER'S MAIDEN NAME GERTAUDE RICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS MRS ALBERT STARK 3603 GLEN AVE, BALTIMORE, MD.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) 420.1 MYOCARDIAL INFARCTION		5 MINUTES
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CORONARY ARTERIOSCLEROSIS		1 YEAR
(c) GENERALIZED ARTERIOSCLEROSIS		5 YEARS
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
NONE		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY		

22. I hereby certify that I attended the deceased from....., 19**50**, to **10-22**, 19**55**, that I last saw the deceased alive on **10-15**, 19**55**, and that death occurred at **8 P** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
burial	10-23-54	Rosevale	Baltimore	MD
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	2. FUNERAL DIRECTOR	ADDRESS	
10-23-55	V.E. Harry	Jack Lewis	2100 Eutan Rd	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

100-100000

100-100000



BUREAU V. S.

OCT 25 1965

RECEIVED

9413

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Carney				OR TOWN Carney X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 06 2615 Joppa Terr.				STREET ADDRESS (If rural give location) 2615 Joppa Terrace			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
ERVIN R. BLOEDORN				Oct. 30, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
male	white	Married	July 5, 1891	64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rtd			10B. KIND OF BUSINESS OR INDUSTRY: Stock Exchange		11. BIRTHPLACE (State or foreign country): Illinois		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Bloedorn				14. MOTHER'S MAIDEN NAME: Annie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes				16. SOCIAL SECURITY NO. (If Yes, give war-on dates of service) World War 2 214-20-6072		17. INFORMANT & ADDRESS: Mrs. Grace A. Bloedorn-2615 Joppa Terr.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) DUE TO Coronary occlusion						7 days	
ANTECEDENT CAUSE (B) DUE TO Cardio-vascular disease						3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Diabetes Mellitus						10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1952, 19, to Oct 30, 1955, that I last saw the deceased alive on Oct. 29, 1955, and that death occurred at 8 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Thomas W. Todd		M. D. 2108 St Paul St.		10/31/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/2/55		Forest Home Cem.		Chicago, Ill	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
11/1/55		A. W. Hedgcock		J. Dickerson & Sons.		Baltimore 17 Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9414

CERTIFICATE OF DEATH

Reg. Dist. No. 09392 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY Balte.
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 2 HRS. 20 MINS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE - 27	03X-1
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 1319 BIRCH AVENUE	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
WILLIAM T. BLOUNT		DATE OF DEATH: OCTOBER 1 19 55	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED	8. DATE OF BIRTH: 8/12/25
9. AGE last birthday 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TECHNICIAN		10B. KIND OF BUSINESS OR INDUSTRY: ELECTRICAL	
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: MACK BLOUNT		14. MOTHER'S MAIDEN NAME: RUTH MCCARRON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 221-72-0863	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION		UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. GLOMERULONEPHRITIS		UNKNOWN	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from OCT. 1, 1955 , to OCT. 1, 1955 , that I saw the deceased alive on OCT. 1, 1955 , and that death occurred at 4:35 PM , from the causes and on the date stated above.			
SIGNATURE WALTER PIJANOWSKI, M.D.		ADDRESS VAH, FORT HOWARD, MD. DATE SIGNED, 10/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10-5-55	
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR OCT. 6-55		REGISTRAR'S SIGNATURE Dan L. Harbor	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD FUNERAL HOME		ADDRESS 1107 Wilkens Av. Baltimore, Md.	

10000

10000

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9415

CERTIFICATE OF DEATH

Reg. Dist. No. 09400

1. PLACE OF DEATH:

COUNTY **BALTIMORE**

MARYLAND

CITY (If outside corporate limits, write RURAL or give nearest town) **FORT HOWARD,**
OR
TOWN **FORT HOWARD,**LENGTH OF STAY
(in this place)
23 DAYSHOSPITAL OR
INSTITUTION OR
STREET ADDRESS**VETERANS ADMINISTRATION HOSPITAL**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTYCITY (If outside corporate limits, write RURAL and give nearest town) **BALTIMORE**
OR
TOWN **BALTIMORE**

STREET ADDRESS (If rural give location)

442 E. CROSS STREET3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

GEORGE**(NMI)****BOERNER**

4. DATE (Month) (Day) (Year)

OF
DEATH: **OCTOBER 8 19 55**

5. SEX:

MALE6. COLOR OR
RACE:**WHITE**7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):**MARRIED**

8. DATE OF BIRTH:

9-1-97

9. AGE last birthday

58 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):**CARPENTER**10B. KIND OF BUSINESS
OR INDUSTRY:**STEEL CO.**

11. BIRTHPLACE (State or foreign country):

BRUNSWICK, MARYLAND12. CITIZEN OF WHAT
COUNTRY?**U.S.A.**

13. FATHER'S NAME:

WALTER E. BOERNER

14. MOTHER'S MAIDEN NAME:

REBECCA MOHN15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)**YES****WW I**

16. SOCIAL SECURITY NO.

214-03-5056

17. INFORMANT & ADDRESS:

CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

MYOCARDIAL INFARCTIONS LEFT VENTRICLE

DUE TO

ANTECEDENT CAUSE (S)

(B)

CORONARY ARTERIOSCLEROSIS AND THROMBOSIS

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

INTERVAL BETWEEN
ONSET AND DEATH**UNKNOWN****UNKNOWN**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

M.

21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **SEPT. 15, 19 55** to **OCT. 8, 19 55** and that death occurred at **7:45A M.** from the causes and on the date stated above.

SIGNATURE

WILLIAM B. VANDERGRIFF

ADDRESS

M. D. VAH, Fort Howard, Md.

DATE SIGNED

10/9/5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)**BURIAL**

DATE THEREOF

10/11/55

NAME OF CEMETERY OR CREMATORY

GLEN HAVEN MEMORIAL PARK

LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

DATE REC'D BY LOCAL
REGISTRAR**10-10-55**

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

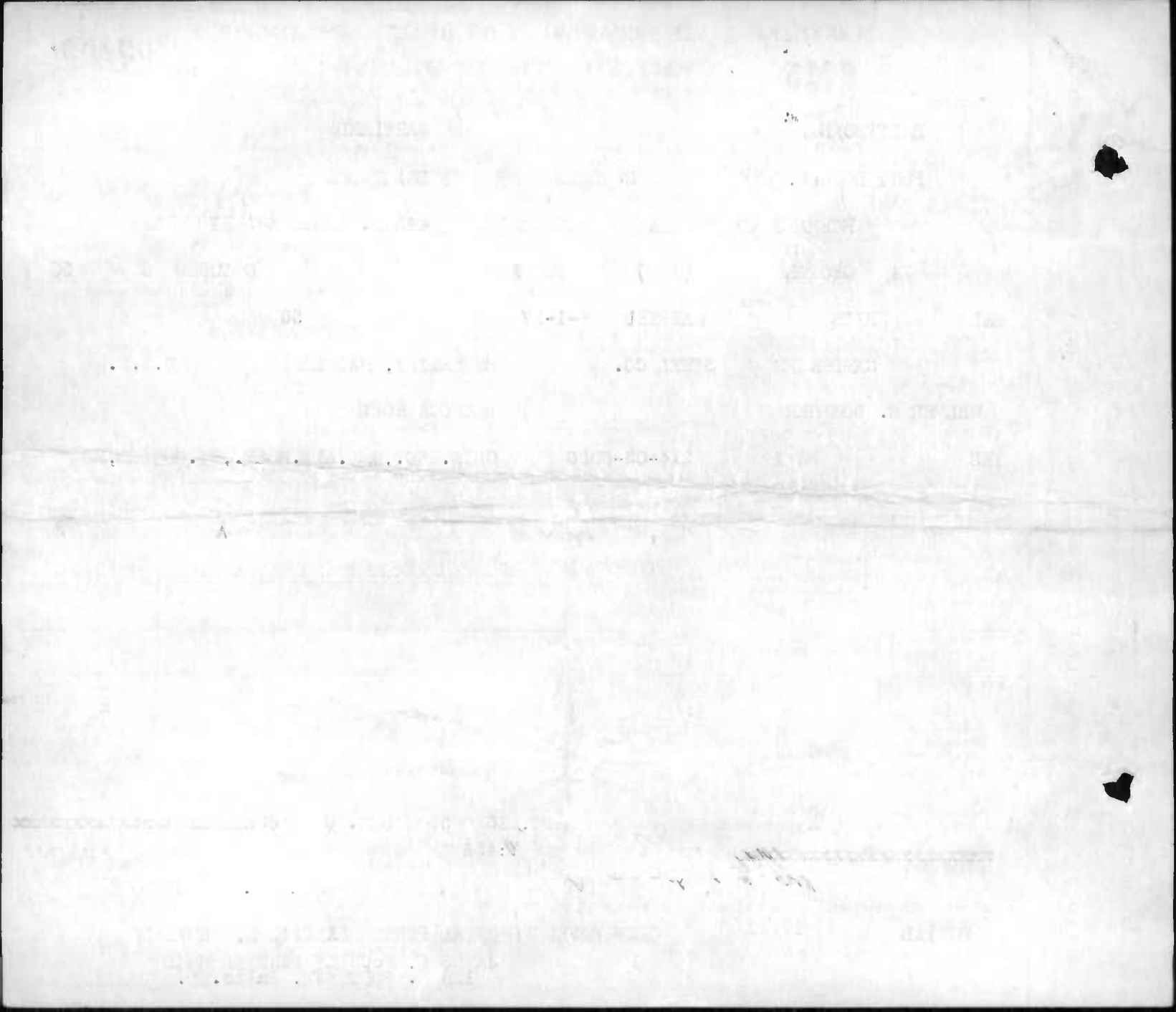
JAMES L. MCCULLY FUNERAL HOME
128 E. FORT AVE. Balto. MD.

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9416

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09401
Reg. Dist.

No. 3

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) 3 mos. 20 days		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Baltimore</u> 3V 01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2476 Shirley Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Frieda</u> <u>Logan</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>October 13,</u> 19 <u>55</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>4-18-71</u>	9. AGE last birthday: <u>84</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> ✓
13. FATHER'S NAME: <u>Gilman</u>			14. MOTHER'S MAIDEN NAME: <u>Rebecca Gilman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
422.1 Immediate cause		(a) <u>Acute cardiac failure</u>			
Antecedent cause(s)		DUE TO			
Diseases or conditions, if any, giving rise to the above cause		(b) <u>Arteriosclerotic cardiovascular disease</u>			
stating underlying cause last		(c) <u>Senility</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Dr. M. Kieffer</u>		1010 Leeds Ave. CHIEF MEDICAL EXAMINER		DATE SIGNED <u>10-13-55</u>	
		M. D. DEPUTY MEDICAL EXAMINER			
		M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Not Capt. Del. Cem</u>	
				LOCATION (City, town, or county) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REG. <u>10/13/55</u>		REGISTRAR'S SIGNATURE <u>D. E. Harry</u>		24. FUNERAL DIRECTOR <u>B. Degenstey & Son</u> ADDRESS <u>5501-14th St NW</u>	

BUREAU V. S.

OCT 14 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9417

CERTIFICATE OF DEATH

Reg. Dist. No. 094024

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 68 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 1000 CRAIN HIGHWAY	

3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE (Month) (Day) (Year)
(Type or Print)	WILLIAM		BOSTON	OF DEATH: OCTOBER 12 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
MALE	COLORED	MARRIED	4-12-95	60 yrs.	Months	Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
LABORER	TANNERY	WATERBURY, MARYLAND	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
DAVID N. BOSTON	MARIE JACOBS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
YES	WW I	Unknown	CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 012.0		
ANTECEDENT CAUSE (S)		
(A) TUBERCULOSIS OF VERTEBRAE T-10, T-11, T-12 AND L-1		UNKNOWN
(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	PARAPLEGIA BACTEREMIA, PROTEUS VULGARIS	UNKNOWN
--	--	----------------

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-18-55	Anterio-lateral decompression of cord Tuberculosis of spine	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
VA M.		

22. I hereby certify that I attended the deceased from **AUG. 5, 1955**, to **OCT. 12, 1955**, and that death occurred at **3:25 AM**, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
Francis G. Dickey, M.D. Chief Medical Service	M.D. VAH, FORT HOWARD, MARYLAND	10-12-55

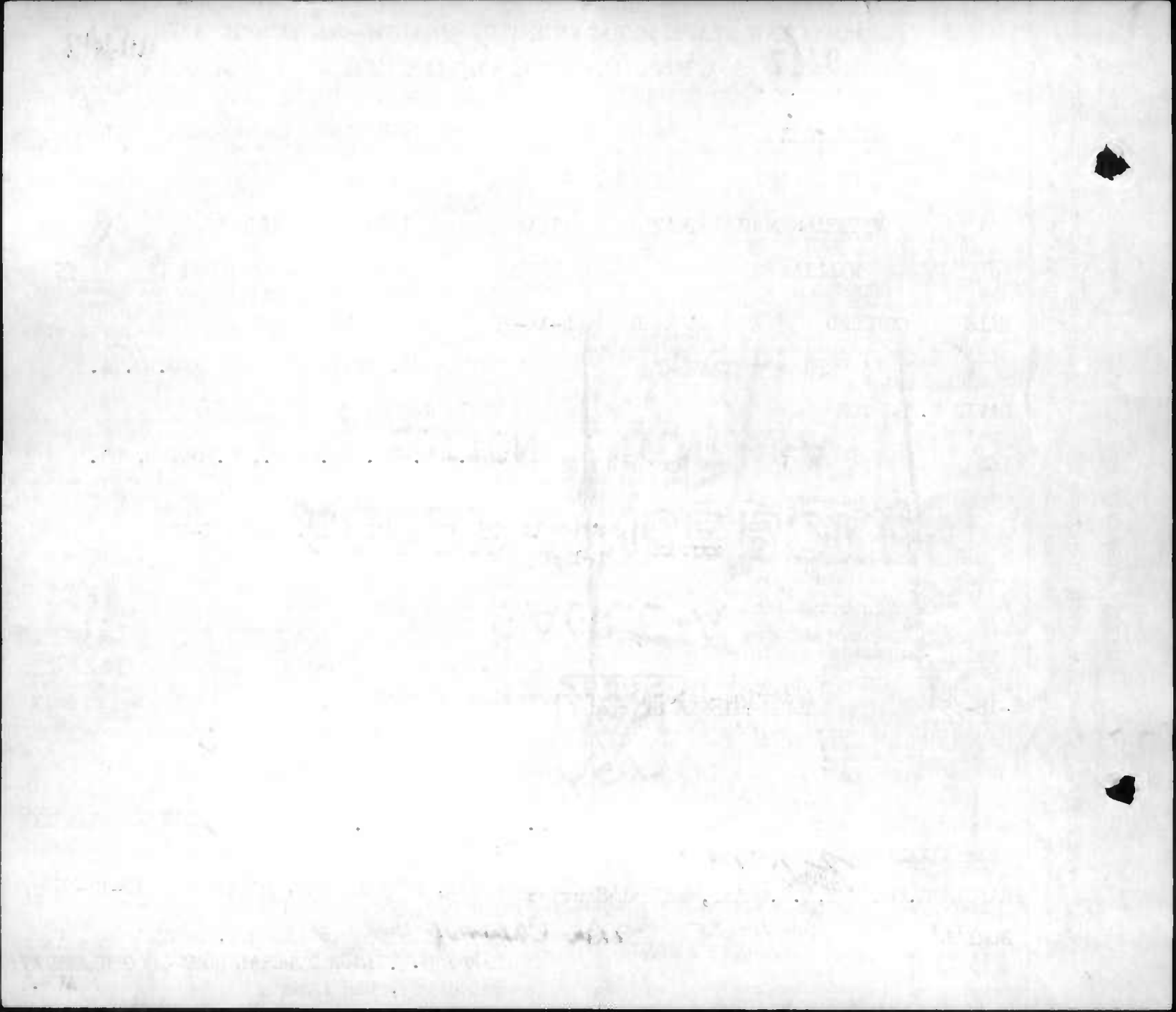
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10-15-55	St Calvary Cem	BALTIMORE, MARYLAND

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	GENERAL DIRECTOR	ADDRESS
10-13-55	6E	ELROY O. WILSON	FUNERAL HOME 1000 BRANTLEY AVE. BALTIMORE, MARYLAND

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9418

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>UPPERCROSS-RURAL</i>	LENGTH OF STAY (in this place) <i>30 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>UPPERCROSS-RURAL</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>1</i>	

3. NAME OF DECEASED: (First) (Middle) (Last) <i>ALBERT - S - BROWN</i>			4. DATE (Month) (Day) (Year) OF DEATH: <i>Oct 5 - 19 55</i>		
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Feb 2 - 1878</i>	9. AGE last birthday <i>77</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>owner</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
13. FATHER'S NAME: <i>John Brown</i>			14. MOTHER'S MAIDEN NAME: <i>Rebecca Myers</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT & ADDRESS: <i>Harlem Brown - Reisterstown Md</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>420.1</i>		<i>1/2 hr</i>
ANTECEDENT CAUSE (S) DUE TO <i>Coronary Thrombosis</i>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Coronary Arterio Scler.</i>		<i>8 yrs</i>
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from *May*, 19*47*, to *Oct 5*, 19*55*, that I last saw the deceased alive on *Oct 5*, 19*55*, and that death occurred at *6:00* M, from the causes and on the date stated above.

SIGNATURE <i>M. B. Ellis</i>	M. O. <i>Harlem Brown</i>	DATE SIGNED <i>10-5-55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Oct 8 55</i>	NAME OF CEMETERY OR CREMATORY <i>Mr Zion</i>
DATE REC'D BY LOCAL REGISTRAR <i>10-5-55</i>	REGISTRAR'S SIGNATURE <i>Mary B. Ellis</i>	FUNERAL DIRECTOR ADDRESS <i>Edw Chilton, Reisterstown Md</i>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

107 04

2110

4-10-55

RECEIVED

4-10-55

BUREAU V. S.

OCT 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09404

9419

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 <u>52</u> <u>Abtownville 28</u>		<u>Since 10/10/55</u>		<u>Havre de Grace 12-24-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 <u>Spring Grove State Hospital</u>				<u>Grovers Hill</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>DAVID</u> <u>BUNCE</u>				<u>10</u> <u>21</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>M</u>	<u>?</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Jacob Bunce</u>				<u>Margaret McCommons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Benignity</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>9.3.55</u>		<u>Carcinoma of Prostate (University Hospital Baltimore)</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10</u> <u>10</u> , 19 <u>55</u> , to <u>10</u> <u>21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10</u> <u>21</u> , 19 <u>55</u> , and that death occurred at <u>6p</u> M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Rena Becker</u>		<u>10-24-55</u>		<u>Darlington Cemetery</u>		<u>Darlington, Harford County, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Burial</u>		<u>10/27/55</u>		<u>V.E. Harry</u>		<u>Pennington & Son, Havre de Grace, Md.</u>	

BUREAU V. R.

RECEIVED

OCT 23 1907

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09405

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> LENGTH OF STAY (in this place) <u>40 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>910 Litchfield Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>Maryland</u> <u>Baltimore</u> STATE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Baltimore</u> STREET ADDRESS <u>910 Litchfield Rd.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Sven</u> (First) <u>Erick</u> (Middle) <u>Carlson</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct 25, 1955</u> 19	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Jan 11, 1881</u>
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>contractor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Hauling</u>	
11. BIRTHPLACE (State or foreign country): <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME: <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>215-32-1825</u>	
17. INFORMANT & ADDRESS: <u>Mrs Lambdin 910 Litchfield Rd.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral accident</u> ANTECEDENT CAUSE (S) <u>QUE TO</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive Cardio-vascular Disease</u> <u>DUE TO</u> (C) <u>Influenza</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 15 min.</u> <u>about 3 yrs.</u> <u>4 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-----</u>			
19A. DATE OF OPERATION: <u>-----</u>		19B. MAJOR FINDINGS OF OPERATION: <u>-----</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>-----</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-----</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>-----</u>			
22. I hereby certify that I attended the deceased from <u>May 17, 1955</u> , to <u>Oct. 25, 1955</u> , that I last saw the deceased alive on <u>Oct. 24, 1955</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. SIGNATURE <u>John A. Moran</u> ADDRESS <u>M.D. 516 Cathedral St.</u> DATE SIGNED <u>Oct. 26, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 28, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemt</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>-----</u>		REGISTRAR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Balto. St.</u>	

1914

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RECEIVED

APRIL 10 1914

FROM

DR. J. H. HARRIS

CHICAGO

TO

DR. J. H. HARRIS

CHICAGO

RECEIVED

APRIL 10 1914

FROM

DR. J. H. HARRIS

9375

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balti-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK - vv - Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK - vv 53</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 88 Baltimore Ave.</u>				STREET ADDRESS (If rural give location) <u>88 Balto. Ave. 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WALTER MILLS Carmine MD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>10 - 13 19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Wn</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 26, 1881</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Physician</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Emp</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Thomas Carmine</u>				14. MOTHER'S MAIDEN NAME: <u>Mary F. Stevens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Dundalk, Md. Mrs. Anita S. Carmine - 88 Balto. Ave.</u>		
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) DUE TO <u>Coronary Occlusion</u>						<u>10 hrs.</u>	
(B) DUE TO <u>Myocarditis, Chronic</u>						<u>2-3 yrs.</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>10/12/55</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 12, 1955</u> to <u>Oct 13, 1955</u> , that I last saw the deceased alive on <u>Oct 12, 1955</u> , and that death occurred at <u>10¹⁵ A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Goars MD</u>		DATE SIGNED <u>10/13/55</u>		M. D. <u>Dundalk - vv Md -</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Denton Cem.</u>		LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/14/55</u>		REGISTRAR'S SIGNATURE <u>Arthur H. H. H.</u>		24. FUNERAL DIRECTOR <u>Thm. J. Lickner & Sons</u>		ADDRESS <u>Md. Balto 17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1935
CERTIFICATE OF DEATH

Page 1 of 2

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Occupation: _____

7. Cause of death: _____

8. Date of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Signature of witness: _____

14. Signature of funeral director: _____

15. Signature of undertaker: _____

16. Signature of cemetery: _____

17. Signature of burial: _____

18. Signature of interment: _____

19. Signature of cremation: _____

20. Signature of other: _____

21. Signature of other: _____

22. Signature of other: _____

23. Signature of other: _____

24. Signature of other: _____

25. Signature of other: _____

26. Signature of other: _____

27. Signature of other: _____

28. Signature of other: _____

29. Signature of other: _____

30. Signature of other: _____

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Occupation: _____

7. Cause of death: _____

8. Date of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Signature of witness: _____

14. Signature of funeral director: _____

15. Signature of undertaker: _____

16. Signature of cemetery: _____

17. Signature of burial: _____

18. Signature of interment: _____

19. Signature of cremation: _____

20. Signature of other: _____

21. Signature of other: _____

22. Signature of other: _____

23. Signature of other: _____

24. Signature of other: _____

25. Signature of other: _____

26. Signature of other: _____

27. Signature of other: _____

28. Signature of other: _____

29. Signature of other: _____

30. Signature of other: _____

WALLEY'S

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G188 11-10-55 et

9421

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09407

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Landover 16 X - 2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) 8620 Landover Road			
3. NAME OF DECEASED: (First) (Middle) (Last) Martha Carr				4. DATE (Month) (Day) (Year) OF DEATH: October 31, 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Divorced	8. DATE OF BIRTH: October 30, 1910	9. AGE last birthday 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry Worker		10B. KIND OF BUSINESS OR INDUSTRY: Ft Meade Camp		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John L. Wilson				14. MOTHER'S MAIDEN NAME: Haddie V. Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 465X Acute pulmonary edema						10 minutes	
ANTECEDENT CAUSE (S) DUE TO (B) Pulmonary thrombosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Dehydration							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-22-1955 to 10-31-1955 , that I last saw the deceased alive on 10-31-1955 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE Sella Wachser		ADDRESS Spring Grove State Hospital		DATE SIGNED 10-31-55		M. D. Catonsville 28, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov 3 1955		NAME OF CEMETERY OR CREMATORY Fort Lincoln		LOCATION (City, town, or county) (State) Colmar Manor Md	
DATE REC'D BY LOCAL REGISTRAR Nov 7-55		REGISTRAR'S SIGNATURE J. J. Severy		24. FUNERAL DIRECTOR F. Pasche		ADDRESS Hyattsville, Md	

BUREAU V. S.

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09408

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 41

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore	MARYLAND	STATE	Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN Dundalk			TOWN Dundalk		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
7501 German Hill Road			7501 German Hill Road		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(Type or Print)	(First)	(Middle)	(Last)	(Month)	(Day) (Year)
Henry	E	Carroll		Oct.	17 1955
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	white	married	May 8, 1887	68 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Nurseryman		Colgate Nursery		Virginia	U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Edward Carroll			Laura Napier		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no				Anna Smith, dght, 514 Quail St., Zone 24	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a) DUE TO					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.		DATE SIGNED	
10/20/55				10/20/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		10/20/55		Oak Lawn Cemetery	
24. FUNERAL DIRECTOR		25. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		Schimunek Funeral Home, Inc.	
10/20/55		A. W. Hedrick		2601-3-5 E. Madison St.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

9422

CERTIFICATE OF DEATH

09409

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Long Green</u>		<u>45 yrs</u>		TOWN <u>Long Green Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lurcia Grace Carter</u>				<u>Oct 21 - 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>W</u>	<u>W</u>	<u>married</u>	<u>Nov 28-1875</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>			<u></u>		<u>Md</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>S. S. Smith</u>				<u>Catherine A. Hoyt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u></u>		<u>D. W. Carter Long Green Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arterio-sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>3 weeks</u>			
STATING UNDERLYING CAUSE LAST, DUE TO				<u>2 yrs</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 20</u> , 19 <u>55</u> , to <u>Oct 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>55</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Halter M. Hammett</u>				<u>Oct 20 - 55</u>			
23. BURIAL, CREMATION, REMOVAL(SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Bural</u>				<u>Oct 24-55</u>		<u>Fork M. Ch. Cem</u>	
						<u>Fork Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct 25-55</u>		<u>G. E. Arthur</u>		<u>G. E. Arthur</u>		<u>Fork Md</u>	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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100-22572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9423
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09410
 Reg. Dist.

No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Reisterstown	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Glyndon	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) Andre (Middle) Cere (Last) Cere		4. DATE OF DEATH (Month) Oct.2 (Day) 19 (Year) 55	
5. SEX: M.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: April 20, 1901
9. AGE last birthday: 54 yrs.		10. BIRTHPLACE (State or foreign country): Bordeaux France	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer Employee		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME: Unknown Cere		14. MOTHER'S MAIDEN NAME: Helena Cere	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 215-32-2523	
17. INFORMANT & ADDRESS: Mrs Arther Foster, Glyndon, Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a) Cerebral Hemorrhage DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			20 min.
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. alcohol Intoxication			1 hr
19a. DATE OF OPERATION: none			19b. MAJOR FINDING OF OPERATION: none
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY none	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY none	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE A. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Oct 3 '55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Oct. 5, 1955	NAME OF CEMETERY OR CREMATORY All Saints Cemetery	LOCATION (City, town, or county) (State) Reisterstown, Md.
DATE REC'D BY LOCAL REG. 10-5-55	REGISTRAR'S SIGNATURE Mary B. Eline	24. FUNERAL DIRECTOR J.F. Eline & Son's ADDRESS Reisterstown, Md.	

BUREAU V. I.

1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

9424

2411 N. Charles Street, Baltimore

09411

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middle River</u>	
TOWN <u>Middle River</u>		TOWN <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Compass Rd.</u>		STREET ADDRESS (If rural, give location) <u>7 Compass Rd.</u>	
3. NAME OF DECEASED (First) <u>Artenia</u> (Middle) <u>S.</u> (Last) <u>Cherry</u>		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>22</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 13, 1884</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Stonebraker</u>		14. MOTHER'S MAIDEN NAME <u>Alice Baughman</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Charles H. Cherry - 7 Compass Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
155X Immediate cause (a) <u>Carcinoma of bladder</u>		3 mos.	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>CA of W.B.</u>	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>53</u> , to <u>Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>55</u> and that death occurred at <u>7:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Marion Rombr</u>		ADDRESS <u>805 Furlage Ave</u>	
DATE SIGNED <u>10-24-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>Oct. 24, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Martinsburg, Pa.</u>		LOCATION (City, town, or county) <u>Martinsburg, Pa.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REG <u>10/24/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
		ADDRESS <u>Lassahn Funeral Home - 7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

2. 1. 1. 1.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

<div style="text-align: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">2</div> <div style="margin-left: 10px;"> MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09412 9425 CERTIFICATE OF DEATH Reg. Dist. No. _____ </div> </div>			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) 52 Catonsville HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital		STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Relay 51 STREET ADDRESS (If rural give location) 4923 Cedar Avenue 1	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Rose (Middle) Anna (Last) Clark		October 17, 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	White	Single	9-16- 1878
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
77 yrs.		None	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
North Carolina		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Aaron Clark		Mary Francois	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Records Spring Grove State Hospital		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 493 X IMMEDIATE CAUSE (A) Pneumonia ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized arteriosclerosis	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
		2 days	
21. I hereby certify that I attended the deceased from 9-19- , 19 55 to 10-17- , 19 55 that I last saw the deceased alive on 10-17- , 1955, and that death occurred at 10:40AM from the causes and on the date stated above.			
SIGNATURE Shula Hachser		DATE SIGNED 10-17-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
Burial		Harry H. Witzke	
DATE REC'D BY LOCAL REGISTRAR 10-19-55		ADDRESS 4101 Edmondson Ave	

11-11-32

UNITED STATES DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

NOV 11 1932

TO THE ATTORNEY GENERAL
FROM THE DIRECTOR
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing a case or investigation.]

9426

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Shady Nook Nursing Home 1002 N. Rolling Rd.</u>		STREET ADDRESS (If rural give location) <u>430 Drury Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY E. CLARKE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 26, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Sept. 13, 1872</u>
9. AGE last birthday: <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Rhineschild</u>		14. MOTHER'S MAIDEN NAME: <u>Finley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Pittsburgh 34, Penna.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE		(A) <u>Cerebral Hemorrhage</u> <u>14 da.</u>	
ANTECEDENT CAUSE (S):		(B) <u>Hypertensive Cardio-Vascular Disease</u> <u>103 yr. (?)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-10</u> , 19 <u>50</u> , to <u>10-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-26</u> , 19 <u>55</u> , and that death occurred at <u>7:15 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William K. Gallagher</u>		ADDRESS <u>Catonsville-28</u>	
DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u>		DATE THEREOF <u>10/29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Maus.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/26/55</u>		REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Lickner</u>		ADDRESS <u>Four-Baltimore 17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
CERTIFICATE OF DEATH
1938

STATE OF MASSACHUSETTS
COUNTY OF _____
CITY OF _____

DECEASED
NAME _____
AGE _____
SEX _____
RACE _____
DATE OF BIRTH _____
DATE OF DEATH _____
PLACE OF DEATH _____
CAUSE OF DEATH _____
MANNER OF DEATH _____
SIGNATURE OF DECEASED _____
SIGNATURE OF NEXT OF KIN _____
SIGNATURE OF PHYSICIAN _____
SIGNATURE OF REGISTRAR _____
DATE OF REGISTRATION _____

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
CERTIFICATE OF DEATH
1938

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09414

9427

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 12, Film 187 10 18 55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>35 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>				STREET ADDRESS (If rural give location) <u>—</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rebecca Sunknoff Cohen</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 8 1955</u>			
5. SEX: <u>f.</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>— 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Not known</u>				14. MOTHER'S MAIDEN NAME: <u>Not known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital records.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>422.1</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Pulmonary embolus</u>							<u>24 hrs</u>
DUE TO <u>arteriosclerotic</u>							
(B) <u>Generalized Cardio-vascular disease</u>							<u>unknown</u>
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Thyroid adenoma, Bilat. Cataract</u>							<u>unknown.</u>
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 8th</u> , 19 <u>55</u> , to <u>Oct 8th</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 8th</u> , 19 <u>55</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Gertrude J. Fleischman</u> M.D.				ADDRESS <u>Spring Grove</u>		DATE SIGNED <u>Oct. 8. 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>10-11-55</u>		<u>Wesdale</u>		<u>Balt. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/11/55</u>		<u>A. W. Sedwick</u>		<u>Jack Lewis Inc.</u>		<u>2100-02 Antaw Place</u>	

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10484

9428

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Items 2,6 Film 191 1-19-56 et

1. PLACE OF DEATH:

County Baltimore
 City or town Bethesda - Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs
 Hospital, institution, or street address where death occurred:
Hood's Convalescent Home
 How long in hospital or institution? 98

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Unknown County Unknown
 City or town Unknown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Unknown
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

Clara Rolley

3. (b) Social Security Number

91

4. Sex Female 5. Color or race W. 6. (a) Single, married, widowed, or divorced Unknown
 6.(b) Name of husband or wife Unknown
 7. Birth date of deceased (mo., day, yr.) Unknown 8. (c) If alive, give age Unknown years
 8. AGE: 84 Years Months Days If less than one day
hrs.min.

9. Birthplace Unknown (Town, county, and state)
 10. Usual occupation Unknown
 11. Industry or business Unknown
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Unknown
 Address Unknown
 17. Cremation Date thereof Nov 8, 1955
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Univ. of Md. Medical School
 Location 29 South Greene St.; Balto. 1, Md.
 18. Funeral director Unknown
 Address Unknown
 19. Nov. 10, 1955 19 Victor E. Barry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 19 55 at 3:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 47 to Oct 21 19 55
 and that I last saw him alive on Oct 20 19 55
 Immediate cause of death C. of Breast DURATION 8 yrs
 Due to Unknown
 Due to Unknown
 Other conditions Generalized Metastasis
170x (Include pregnancy within 3 months of death)
 Major findings of operations Unknown Date of op. Unknown

Autopsy results Unknown
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Unknown Date of Unknown
 Where did injury occur? Unknown (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Unknown
 Means of injury Unknown Injured at work? Unknown
 23. SIGNATURE James Esfowes M. D. or other Unknown
Catonsville Address Unknown Date signed 10-21

BUREAU V. S.

NOV 10 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

9429

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 35

Item 7, Film G187 10-19-55 et

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pa.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>		STREET ADDRESS (If rural, give location) <u>816 Hamilton Blvd</u>	
3. NAME OF DECEASED (First) <u>Cheta</u> (Middle) <u>Arthur</u> (Last) <u>Corvington</u>		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 12, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Corvington</u>		14. MOTHER'S MAIDEN NAME <u>Ananda Jenta</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World I</u>		16. SOCIAL SECURITY No. <u>318-14-6244</u>	
17. INFORMANT AND ADDRESS <u>Carroll E. F. Horne, Getchfield, Ill.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>812X</u> (a) <u>Crushed skull, compound fracture of both lower extremities</u>			
Antecedent cause(s) (b) <u>of both lower extremities</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Highway 111</u> (CITY OR TOWN) <u>Baltimore</u> (COUNTY) <u>Balt.</u> (STATE) <u>Ind</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 3, 1955 6:15 pm</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Struck by automobile</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>C. H. France M.D.</u>		DATE SIGNED <u>10/3/55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10-12-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Alton Nat. Cemetery</u>		LOCATION (City, town, or county) <u>Alton, Illinois</u> (State)	
DATE REC'D BY LOCAL REG. <u>10/12/55</u>		24. FUNERAL DIRECTOR <u>Brooks Funeral Service, Sparks, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COR.

Corbett

RECEIVED

OCT 14 1955

BUREAU V. 2

NOV 14 1955
RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 188 10-31-55 et

CERTIFICATE OF DEATH

09416

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>A. A.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>52 Catonsville 28</i>		LENGTH OF STAY (in this place) <i>Cons. Feb 20, 1954</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore Severna Park 0280</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove Hospital</i>				STREET ADDRESS (If rural give location) <i>Cypress Creek Road</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <i>CARRIE MARIE DALEY</i>				<i>10 16 1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>August 16, 1873</i>	9. AGE last birthday: <i>82</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>at home</i>		11. BIRTHPLACE (State or foreign country): <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Adam Treulich</i>				14. MOTHER'S MAIDEN NAME: <i>Catherine Gable</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS: <i>P.O. Box 299 Mrs. T. Morris Jones, Severna Park</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.0</i>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>Arteriosclerotic Cardiac Disease</i>							
DUE TO							
(B) <i>Generalized Arteriosclerosis</i>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Rt Hemiplegia</i>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8. 24. , 1955</i> , to <i>10. 16 , 1955</i> , that I last saw the deceased alive on <i>10. 16 , 1955</i> , and that death occurred at <i>11 a.m.</i> from the causes and on the date stated above.							
SIGNATURE <i>Rena Becker</i>		M.D. <i>Spring Grove Hosp.</i>		DATE SIGNED <i>10/16/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10/19/55</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>10-18-55</i>		REGISTRAR'S SIGNATURE <i>John H. ...</i>		24. FUNERAL DIRECTOR <i>Wm. Cook Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	

FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-374301)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

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09417

9431

CERTIFICATE OF DEATH

Reg. Dist. No. 44

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>93 Days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2537 Greenmount Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>REUBEN</u> (Middle) <u>D.</u> (Last) <u>DAVIS</u>				(Month) <u>October</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>1/3/86</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dunbar T. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Forney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>LEFT CEREBRAL HEMORRHAGE</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> <u>I</u> attended the deceased from <u>July 25</u> , 19 <u>55</u> , to <u>October 26</u> , 19 <u>55</u> , that the cause of death was <u>LEFT CEREBRAL HEMORRHAGE</u> and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>OCT 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Garber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. Md.</u>			

• 2 •

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09418

9432

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
TOWN <u>PARKVILLE</u>		TOWN <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2915 Roberson Ave</u>		STREET ADDRESS <u>2915 Roberson Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>CORA</u> (First) <u>M</u> (Middle) <u>DEAN</u> (Last)		4. DATE OF DEATH (Month) <u>OCT</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. STATUS <u>WIDOWED</u> (Specify)	8. DATE OF BIRTH <u>Nov. 13, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John PRITCHETT</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET Motherset</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Lloyd B Dean</u>		17. ADDRESS <u>2915 Roberson Ave</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
442X Immediate cause (a) <u>Cerebral Thrombosis</u>			<u>2 wks</u>
Antecedent cause(s) (b) <u>arteriosclerotic cardiovascular disease</u>			<u>10 yrs</u>
(c) <u> </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>April 9, 1940</u> to <u>Oct 6, 1955</u> , that I last saw the deceased alive on <u>Oct 6, 1955</u> , and that death occurred at <u>4:15 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. J. J. J.</u>		ADDRESS <u>6217 Harford Rd Baltimore Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>10-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) <u>BALTO</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>10/8/55</u>		REGISTRAR'S SIGNATURE <u>A. M. J. J.</u>	
24. FUNERAL DIRECTOR <u>Chas F. Evans & Son</u>		ADDRESS <u>5802 Harford Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

* Dr. E. J. Alessi
6217 Harford Rd

BUREAU V. S.

OCT 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9433

CERTIFICATE OF DEATH

Reg. Dist. No. 77

09419

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY DORCHESTER
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN FORT HOWARD	LENGTH OF STAY (in this place) 7 Hours, 35 M.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN EAST NEW MARKET	09X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) DUDLEY R. DEMBY		4. DATE (Month) (Day) (Year) OF DEATH: OCTOBER 2 1955	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 10-18-26
9. AGE last birthday 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKMAN		10B. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country): EAST NEW MARKET, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JAMES DEMBY		14. MOTHER'S MAIDEN NAME: FRANCES FARROW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) YES KOREAN		16. SOCIAL SECURITY NO. 218-16-6754	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP. FT. HOWARD, MARYLAND			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) GLIOMA, RIGHT LATERAL VENTRICLE			UNKNOWN
DUE TO			
ANTECEDENT CAUSE (B)			
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 10-2-55		19B. MAJOR FINDINGS OF OPERATION: CRANIOTOMY - BILATERAL TREPHINE- TRACHEOSTOMY	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from OCT. 1, 1955 , to OCT. 2, 1955 ; that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 10-3-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF OCT. 5, 1955	
NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEMETERY		LOCATION (City, town, or county) (State) EAST NEW MARKET, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR OCT. 4, 1955		FURNERAL DIRECTOR ADDRESS J. J. FRAMPTON & SON, FEDERALSBURG, MD. MAIN STREET	

BUREAU V. E.

OCT 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09420

9434

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7912 Ruxway Rd. Sorenson Nursing Home</u>				STREET ADDRESS (If rural give location) <u>5015 Roland Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 9, 19 55</u>			
5. SEX: <u>female</u>				6. COLOR OR RACE: <u>white</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>				8. DATE OF BIRTH: <u>Oct. 5, 1874</u>			
9. AGE last birthday <u>81</u> yrs.				10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>			
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>Harry Paul Owens</u>				14. MOTHER'S MAIDEN NAME: <u>Jane Foster Owen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>Miss Estelle Dennis - 100 E. Monument St.</u>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>422.2</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>anaemia</u>							<u>2 months</u>
DUE TO							
(B) <u>Chronic Glomerular Nephritis.</u>							<u>5 years.</u>
DUE TO							
(C) <u>myocarditis Chronic.</u>							<u>5 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>anarabec.</u>							<u>1 year.</u>
19A. DATE OF OPERATION: <u>none</u>				19B. MAJOR FINDINGS OF OPERATION: <u>none.</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 2, 1955</u> , to <u>Oct. 8, 1955</u> , that I last saw the deceased alive on <u>Oct. 8, 1955</u> , and that death occurred at <u>8.30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G. M. Graham Monitor</u>		ADDRESS <u>M. D. 516 Cathedral St</u>		DATE SIGNED <u>10-10-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Chas. J. Lickner & Sons - Balto.</u>		ADDRESS <u>17 A</u>	

9435

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>FORT HOWARD</u>		<u>44 DAYS</u>		OR TOWN <u>BALTIMORE</u> <u>3001-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1206 WEST FRANKLIN STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>EDWARD C. DOCKINS</u>				OF DEATH: <u>OCTOBER 12, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLORED</u>	<u>MARRIED</u>	<u>7-11-90</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>POST OFFICE</u>		<u>BALTIMORE, MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>YES</u> <u>WW-1</u>				<u>UNKNOWN</u>		<u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u>							
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROSIS, GENERALIZED WITH HEMI-</u>							
<u>PARISIS</u>							<u>2 MONTHS</u>
ANTECEDENT CAUSE (S) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							<u>UNKNOWN</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<u>VA</u>				<u>VA</u>			
22. I hereby certify that I attended the deceased from <u>August 29, 1955</u> , to <u>Oct. 12, 1955</u> , and I last saw the deceased <u>alive on 10-12-55</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS		DATE SIGNED	
<u>FRANCIS G. DICKEY, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND 10-13-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-17-1955</u>		<u>BALTIMORE NATIONAL</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/14/55</u>		<u>a. b. Hedrick</u>		<u>CHARLES G. COOPER, 512 N. CARROLTON AVE.</u>		<u>BALTIMORE, MARYLAND</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9389

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09422

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4K

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
51 TOWN <u>Arbutus</u>	3 wks	TOWN <u>Arbutus</u>	<u>Westland 51</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4813 Fernley Square</u>		STREET ADDRESS (If rural, give location) <u>4813 Fernley Square</u>	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	<u>John Joseph Drake</u>	<u>Oct</u>	<u>19</u> <u>55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>m</u>	<u>w</u>	<u>widowed</u>	<u>Oct 12 1884</u>
9. AGE last birthday:		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>71</u> yrs.		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Retired</u>	<u>hatchman</u>	<u>Ireland</u>	<u>U.S.A.</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Drake</u>		<u>Mary unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkn.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
			<u>John Drake 4813 Fernley Square</u>

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
422.1 Immediate cause		(a) <u>Acute Cardiac failure</u>	
Antecedent cause(s)		DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b) <u>Cardiovascular disease</u>	
		(c)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER	
<u>Dr. W. Kieffer</u>		<u>1010 Leeds Ave</u>	
		DEPUTY MEDICAL EXAMINER	
		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	
<u>Burial</u>		<u>10-21-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St Peter</u>		<u>Balto</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Oct 19 55</u>		<u>Amara Hubbard</u>	
		ADDRESS <u>4107 Guilman</u>	

BUREAU V. S.

OCT 24 1963

RECEIVED

9436

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Chase
 TOWN 18 months
 HOSPITAL OR INSTITUTION OR STREET ADDRESS EBENEZER R.R.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTIMORE
 CITY (If outside corporate limits, write RURAL and give nearest town) CHASE MD
 TOWN CHASE MD
 STREET ADDRESS (If rural give location) EBENEZER RD

3. NAME OF DECEASED:

(First) FRANCIS (Middle) DRAKE (Last) DUNLAP
 (Type or Print)

4. DATE OF DEATH: 10 (Month) 28 (Day) 1955 (Year)

5. SEX:

MALE

5. COLOR OR RACE:

N

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

M

8. DATE OF BIRTH:

11/16/1875

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

79 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

MECH. RETIRED PENN. R.R.

10b. KIND OF BUSINESS OR INDUSTRY:

DELAWARE CITY DEL

11. BIRTHPLACE (State or foreign country):

DELAWARE CITY DEL

12. CITIZEN OF WHAT COUNTRY?

DELAWARE CITY DEL

13. FATHER'S NAME:

FRANCIS B.

14. MOTHER'S MAIDEN NAME:

SARAH J. GARDNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY No.:

AMELIA Dunlap CHASE MD

17. INFORMANT & ADDRESS:

AMELIA Dunlap CHASE MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a) Coronary Occlusion
 DUE TO

Antecedent causes (s)
 Diseases or conditions, if any,
 giving rise to the above cause
 stating the underlying cause last.

(b) Arteriosclerotic Cardio-Vascular disease
 DUE TO

(c)

Interval Between Onset And Death

10/27/55

2 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

NO

19b. MAJOR FINDINGS OF OPERATION

NO

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

NO

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1955, to Oct 28, 1955, that I last saw the deceased alive on Oct 28, 1955, and that death occurred at 7 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

DATE THEREOF

10/31/55

NAME OF CEMETERY OR CREMATORY

OAK LAWN

LOCATION (City, town, or county)

BALTIMORE MD

(State)

MD

DATE REC'D BY LOCAL REGISTRAR

Oct 29, 1955

REGISTRAR'S SIGNATURE

R.W.

24. FUNERAL DIRECTOR

Blair F. Hoffmann

ADDRESS

3218 Hudson

MARGIN RESERVED FOR BINDING

1933

1933

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09424
33
Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Reisterstown		CITY (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Bond Ave.		STREET ADDRESS (If rural, give location) 19 Bond Ave.	
3. NAME OF DECEASED (Type or Print) Fannie	(First)	(Middle) E.	(Last) Dutton
4. DATE OF DEATH Oct. 22	(Month)	(Day)	(Year) 1955
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Mar. 22, 1875
9. AGE last birthday 80 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Walter Little		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or dates of service)		16. SOCIAL SECURITY No. none.	
17. INFORMANT AND ADDRESS Mrs. Janice Johnson 19 Bond Ave.			

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443 X Immediate cause (a) Cardiac Decompensation		2 yrs.
Antecedent cause(s) (b) Hypertensive C-V. Disease		5 yrs.
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none.	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) none	PLACE (Home, farm, factory, street, OF office bldg., etc.) none	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY none. m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> none.	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-28**, 19**50**, to **10-22**, 19**55**, that I last saw the deceased alive on **10-21**, 19**55**, and that death occurred at **9:30 a.m.**, from the causes and on the date stated above.

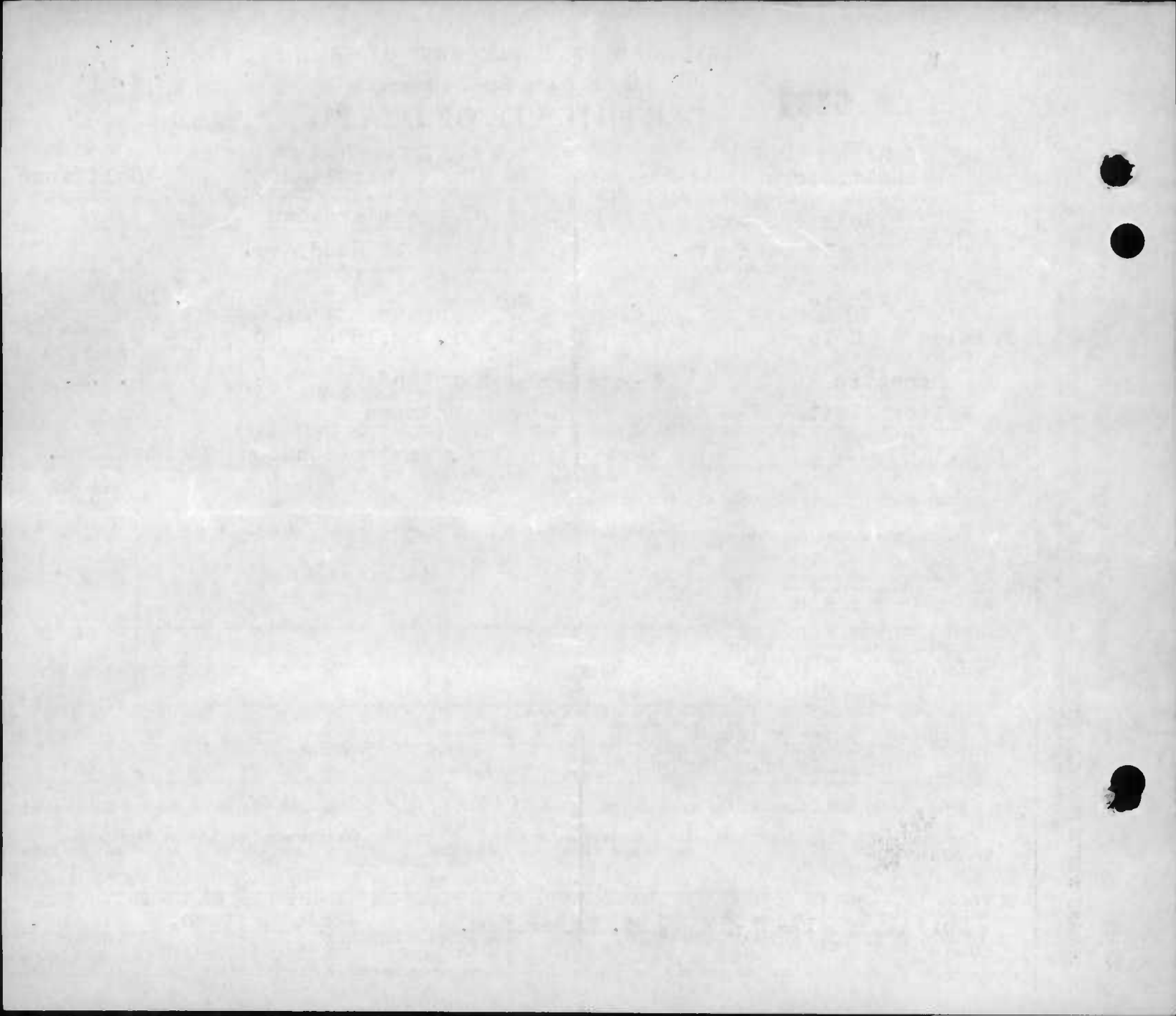
SIGNATURE **D. D. Caples** (Degree or title) **M.D. Reisterstown, Ind.** ADDRESS **10-24-53** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 10-25-55	NAME OF CEMETERY OR CREMATORY St. Lukes Cem.	LOCATION (City, town, or county) Reisterstown,	(State) Md.
DATE REC'D BY LOCAL REG. 10/25/55	REGISTRAR'S SIGNATURE U. W. Hedrick	24. FUNERAL DIRECTOR M. J. Hensley	ADDRESS 578	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09425

9438

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>15 Days</u>		TOWN <u>Annapolis</u>		<u>02-10-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>61 Clay Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ENOCH</u> (Middle) <u>ERIC (ERRIC)</u> (Last) <u>EBEN</u>				(Month) <u>October</u> (Day) <u>20</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>July 1, 1896</u>	<u>59</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cook</u>		<u>Hospital</u>		<u>Gaysville, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Eben</u>				<u>Elizabeth MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>WW I</u>		<u>Unknown</u>			
				<u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>153X</u> IMMEDIATE CAUSE (A) <u>ADENOCARCINOMA OF COLON</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>September 1, 1955</u>				<u>Laparotomy and ileo transverse colostomy</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>October 5, 1955</u>, to <u>October 20, 1955</u>, and that death occurred at <u>9:15 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
DATE THEREOF <u>10-22-55</u>				NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>			
BUTIAL <u>Burial</u>				LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>			
REC'D BY REGISTRAR <u>William Reece</u>				FUNERAL DIRECTOR'S SIGNATURE <u>William Reece</u>			
DATE <u>10-22-55</u>				ADDRESS <u>William Reece Funeral Home, Annapolis, Md.</u>			

INVESTIGATION

1
The following information was obtained from the records of the Bureau of Health and State Department of Health-Baltimore, Md.
The name of the deceased is [redacted]
The date of death is [redacted]
The place of death is [redacted]
The cause of death is [redacted]
The attending physician is [redacted]
The funeral home is [redacted]
The burial place is [redacted]
The date of burial is [redacted]
The name of the informant is [redacted]
The address of the informant is [redacted]
The date of the report is [redacted]

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

8138

Rev. 1911, No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. ATTENDING PHYSICIAN

8. FUNERAL HOME

9. BURIAL PLACE

10. DATE OF BURIAL

11. NAME OF INFORMANT

12. ADDRESS OF INFORMANT

13. DATE OF REPORT

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL PLACE

19. SIGNATURE OF DATE

20. SIGNATURE OF TIME

21. SIGNATURE OF PLACE

22. SIGNATURE OF CAUSE

23. SIGNATURE OF ATTENDING

24. SIGNATURE OF FUNERAL

25. SIGNATURE OF BURIAL

26. SIGNATURE OF DATE

27. SIGNATURE OF NAME

28. SIGNATURE OF ADDRESS

29. SIGNATURE OF DATE

30. SIGNATURE OF REPORT

31. SIGNATURE OF SIGNATURE

32. SIGNATURE OF DECEASED

33. SIGNATURE OF WITNESSES

34. SIGNATURE OF FUNERAL HOME

35. SIGNATURE OF BURIAL PLACE

36. SIGNATURE OF DATE OF BURIAL

37. SIGNATURE OF NAME OF INFORMANT

38. SIGNATURE OF ADDRESS OF INFORMANT

39. SIGNATURE OF DATE OF REPORT

40. SIGNATURE OF SIGNATURE OF REGISTRAR

41. SIGNATURE OF SIGNATURE OF DECEASED

42. SIGNATURE OF SIGNATURE OF WITNESSES

43. SIGNATURE OF SIGNATURE OF FUNERAL HOME

44. SIGNATURE OF SIGNATURE OF BURIAL PLACE

45. SIGNATURE OF SIGNATURE OF DATE

46. SIGNATURE OF SIGNATURE OF TIME

47. SIGNATURE OF SIGNATURE OF PLACE

48. SIGNATURE OF SIGNATURE OF CAUSE

49. SIGNATURE OF SIGNATURE OF ATTENDING

50. SIGNATURE OF SIGNATURE OF FUNERAL

51. SIGNATURE OF SIGNATURE OF BURIAL

52. SIGNATURE OF SIGNATURE OF DATE

53. SIGNATURE OF SIGNATURE OF NAME

54. SIGNATURE OF SIGNATURE OF ADDRESS

55. SIGNATURE OF SIGNATURE OF DATE

56. SIGNATURE OF SIGNATURE OF REPORT

57. SIGNATURE OF SIGNATURE OF SIGNATURE

58. SIGNATURE OF SIGNATURE OF DECEASED

59. SIGNATURE OF SIGNATURE OF WITNESSES

60. SIGNATURE OF SIGNATURE OF FUNERAL HOME

61. SIGNATURE OF SIGNATURE OF BURIAL PLACE

62. SIGNATURE OF SIGNATURE OF DATE OF BURIAL

63. SIGNATURE OF SIGNATURE OF NAME OF INFORMANT

64. SIGNATURE OF SIGNATURE OF ADDRESS OF INFORMANT

65. SIGNATURE OF SIGNATURE OF DATE OF REPORT

66. SIGNATURE OF SIGNATURE OF SIGNATURE OF REGISTRAR

67. SIGNATURE OF SIGNATURE OF SIGNATURE OF DECEASED

68. SIGNATURE OF SIGNATURE OF SIGNATURE OF WITNESSES

69. SIGNATURE OF SIGNATURE OF SIGNATURE OF FUNERAL HOME

70. SIGNATURE OF SIGNATURE OF SIGNATURE OF BURIAL PLACE

BUREAU A

OCT 20

WFO

10-2-22

1 9439

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) Catonsville (in this place)
52 TOWN
HOSPITAL OR Wayne Nursing Home
90 INSTITUTION OR
STREET ADDRESS 98 Smithwood Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)
OR Baltimore 3001-4
TOWN
STREET (If rural give location)
ADDRESS formerly of 357 Yale Ave. ✓

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

EMMA

EMILY

EBERT

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Oct

30

1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

female

white

single

Feb. 14, 1872

83

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.

Ptd Dressmaker

10b. KIND OF BUSINESS OR INDUSTRY:

self employed

11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

John C. Ebert

14. MOTHER'S MAIDEN NAME:

Margaret Schell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

no

17. INFORMANT & ADDRESS:

Mr. Henry Ebert-704 Woodbourne Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work

Not While At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 1955, to Oct 5, 1955, that I last saw the deceased

alive on 28 Oct 55

SIGNATURE

19....., and that death occurred at 11:45 A.M.

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

11/2/55

NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cem.

LOCATION (City, town, or county)

Balto., Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00128

00128

9440

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lutherville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Road</u>				STREET ADDRESS (If rural give location) <u>York Road</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Emma</u>		(Middle) <u>Ecker</u>		(Last)		OF DEATH: <u>Oct. 23, 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Oct. 6, 1869</u>	
9. AGE last birthday: <u>85</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Peschke</u>				14. MOTHER'S MAIDEN NAME: <u>Fischer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Family Records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>myocardial degeneration</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Sensitiz</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15th Oct.</u> , 1955, to <u>23rd Oct.</u> , 1955, that I last saw the deceased alive on <u>10/18/</u> , 1955, and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. K. Quinn</u>		ADDRESS <u>York Rd., TIMONIUM</u>		DATE SIGNED <u>10/25/55</u>			
23. BURIAL, CREMATION, <u>Partial Cremation</u>		DATE THEREOF <u>Oct. 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Freemount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 26 1935

RECEIVED

09428

9441

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Item 21 Film G 188 11-9-55 ans

Item 4, Film G188 10-31-55 et

FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural, give location) 1101 N. CAREY STREET	
3. NAME OF DECEASED (First) WILLIAM	(Middle) E.	(Last) EPPS	4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 19 18, 1955
5. SEX MALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 9-22-95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 60 yrs.
11. BIRTHPLACE (State or foreign country) FREDERICKSBURG, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAMUEL E. EPPS		14. MOTHER'S MAIDEN NAME EMILY JACKSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
903.5 Immediate cause (a) CRUSHING INJURY, CERVICAL SPINAL CORD Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		6 DAYS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY in front of home	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) 10-12-55	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Blacked out and fell on street

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

REMOVAL (Specify)

10/21/55**BALTIMORE NATIONAL****BALTIMORE, MARYLAND**

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

MINISTERIAL DIRECTOR

ADDRESS

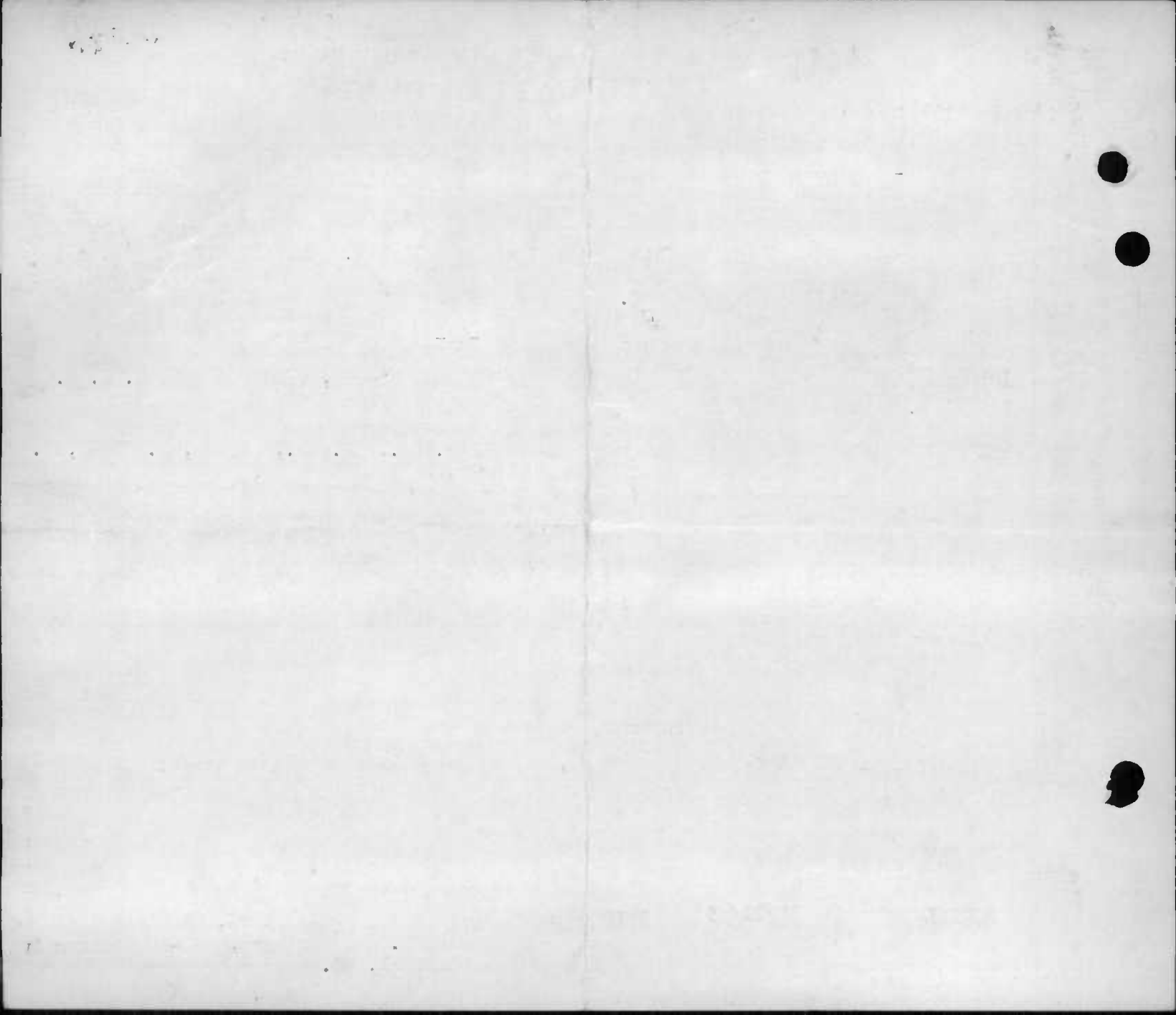
REG

10/1-20/55 + 180. Adriel**Charles R. Law Mortuary, 802-04 Madison Ave****Baltimore 1, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09429

9377

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY Turner Station MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Turner Station TOWN Turner Station HOSPITAL OR INSTITUTION OR STREET ADDRESS 710 Avondale Road		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Turner Station CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location) 710 Avondale Rd.	
3. NAME OF DECEASED: (Type or Print) Joseph William Everett		4. DATE (Month) (Day) (Year) OF DEATH: 10 22 19 55	
5. SEX: M	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: June 11, 1946
9. AGE last birthday: 9 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Gastonia, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: James M. Everett		14. MOTHER'S MAIDEN NAME: Bertha Truitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Rev. J. A. Everett 710 Avondale Rd.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Hypertension + uremia			1 wk.
ANTECEDENT CAUSE (S) DUE TO (B) Renal failure			3 wks.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Brain tumor			5 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-19-55 , to 10-22-55 , that I last saw the deceased alive on 10-22-55 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
SIGNATURE Harold Nichols		ADDRESS 10-24-55	
M. D. 10-24-55		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/25/55	
NAME OF CEMETERY OR CREMATORY Carver Memorial Park		LOCATION (City, town, or county) (State) Murkirk, Maryland	
DATE REC'D BY LOCAL REGISTRAR Oct 25-1955		REGISTRAR'S SIGNATURE William M. Kelly	
24. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802-04 Madison Ave.	

COMMITTEE ON CRIMINALS

RECEIVED

OCT 27 1955

BUREAU V. 2

9442

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09430

Reg. Dist. No. *24*

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bethlehem Steel Corporation		STREET ADDRESS (If rural, give location) 242 N. Monroe Street	
3. NAME OF DECEASED (Type or Print)	(First) Maynard	(Middle) Ernseliff	(Last) Falden
5. SEX M	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH January 1, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	11. BIRTHPLACE (State or foreign country) Danville, Virginia
13. FATHER'S NAME Charles H. Falden		14. MOTHER'S MAIDEN NAME Anna L. Fitzgerald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Verba F. Dorsey		1516 McCulloch St.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Coronary Occlusion Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

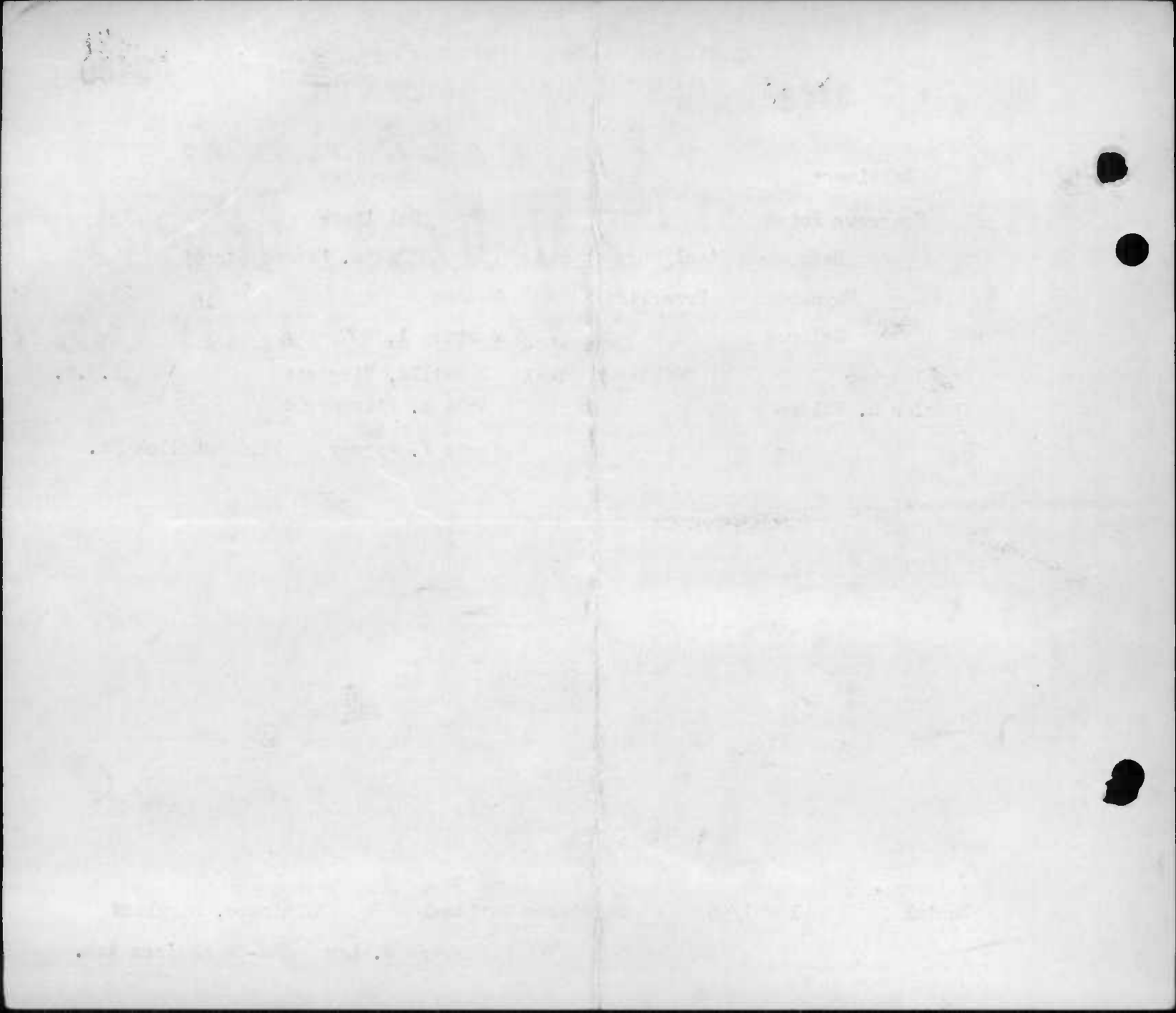
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/31/55	Baltimore National	Baltimore, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		Charles R. Law	802-04 Madison Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09431

9443

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Ruxton</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Balto.</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Sorenson Home</u>		STREET ADDRESS (If rural give location) <u>2102 South Rd.</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HELEN S. FERTIG</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 8,</u> 19 <u>55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>married</u>	8. DATE OF BIRTH: <u>June 2, 1892</u>
		9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at Home</u>	11. BIRTHPLACE (State or foreign country): <u>California</u>
13. FATHER'S NAME: <u>Albert Leech</u>		14. MOTHER'S MAIDEN NAME: <u>Janet Rierson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mr. Kenneth W. Fertig - 2102 South Rd.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Inoperable carcinoma (pelvic)</u>			<u>about 1 year</u>
ANTECEDENT CAUSE (S) <u>DUE TO</u>			
(B) <u>Internal Hemorrhage</u>			<u>about 2 hours</u>
(C) <u>Cessation of all bodily functions</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardio-vascular Disease</u>			<u>about 15 years</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 18, 1955</u> , to <u>Oct. 8, 1955</u> , that I last saw the deceased alive on <u>Oct. 3, 1955</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Amal S. M. M.</u>		ADDRESS <u>516 Cathedral St.</u> DATE SIGNED <u>Oct. 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/8/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Kensico Cem.</u>		LOCATION (City, town, or county) (State) <u>Valhalla, N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 9 - 1955</u>		REGISTRAR'S SIGNATURE <u>M. J. Lickens & Sons - Balto 17</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>med.</u>	

BUREAU V. 8

OCT 13 1955

RECEIVED

9390

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
57 TOWN <i>Halethorpe</i>				51 TOWN <i>Halethorpe</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Craddock Home</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<i>Robert Emmett Sinks</i>				<i>Oct. 8, 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>Caucasian</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <i>Aug. 14, 1885</i>	
						9. AGE last birthday <i>70</i> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Plumber</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Plumber</i>		11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <i>Edward B. Sinks</i>			
14. MOTHER'S MAIDEN NAME: <i>Ida B. Sinks</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS: <i>Mrs. Emily S. Sinks 1731 Birch Hill Ave.</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
334X IMMEDIATE CAUSE (A) <i>Hemiplegia</i>							
ANTECEDENT CAUSE: (B) <i>Bed Sores, + General weakness</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Hypertension</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-23, 1954</i> to <i>10-8, 1955</i> that I last saw the deceased alive on <i>10-7, 1955</i> , and that death occurred at <i>7:10 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Thos. Woolridge</i>		M. D. <i>R. B. Sinks</i>		DATE SIGNED <i>Oct 27 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Oct. 12, 1955</i>		<i>Mt. Auburn</i>		<i>Baltimore, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>10-11-55</i>		REGISTRAR'S SIGNATURE <i>A. V. Hedrick</i>		24. FUNERAL DIRECTOR <i>Funeral Home</i>		ADDRESS <i>1631 Birch Hill Ave.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

the map shows
the area + general features
the features

1-9-40

at 10-10-40
at 10-10-40
at 10-10-40

10-10-40
10-10-40
10-10-40

MARYLAND STATE DEPARTMENT OF HEALTH

09433

2411 N. Charles Street, Baltimore

9444

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparks Pt 19</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparks Pt 19</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>820 J Street</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Oxley</u> (Last) <u>Finney</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>7th</u> (Year) <u>1955</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. STATUS <u>WIDOWED</u> (Specify)	8. DATE OF BIRTH <u>April 12 1863</u>
9. AGE last birthday <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>2-006-0298</u>	
17. INFORMANT AND ADDRESS <u>Mamie White</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

Immediate cause

(a)

Lobar pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		(CITY OR TOWN)	
TIME (Month) (Day) (Year) (Hour)		PLACE (Home, farm, factory, street, office bldg., etc.)		(COUNTY)	
OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct 1st, 1955, to Oct 7th, 1955, that I last saw the deceasedalive on October 7th, 1955, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>10-11-55</u>		<u>Mt. Calvary</u>		<u>AA Co., Md.</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>October 8th 1955</u>		<u>R.W.</u>		<u>Charles R. Law</u>		<u>802 Madison Ave.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Transcript

9445

CERTIFICATE OF DEATH

Reg. Dist. No. *24*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 20 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE <i>3401.4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL <i>50</i>				STREET ADDRESS (If rural give location) 633 WEST FRANKLIN STREET ✓			
3. NAME OF DECEASED: (First) WILLIAM		(Middle) (NMI)		(Last) FISHER (Willie)		4. DATE (Month) (Day) (Year) OF DEATH: OCTOBER 16, 19 55	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: 7/12/05	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY: BETH. STEEL CO.		11. BIRTHPLACE (State or foreign country): BLACKSTOCK, S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: ALEX FISHER				14. MOTHER'S MAIDEN NAME: ROSE BLACKMORE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES ✓ (If Yes, give war or dates of service) WW II		16. SOCIAL SECURITY No. Unknown		17. INFORMANT & ADDRESS: CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) LUPUS ERYTHEMATOSIS							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 26, 19 55 , to OCT. 16, 19 55 , and that death occurred at 11:00 M. , from the causes and on the date stated above. SIGNATURE WILLIAM B. VANDEGRIFT, M.D. ADDRESS M. D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 10-17-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10/20/55		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-18-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR CHARLES R. LAW MORTUARY		ADDRESS 802-04 MADISON AVE. BALTIMORE 1, MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10506

9446

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville	LENGTH OF STAY (in this place) 6yr 5mos 6days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital		STREET ADDRESS (If rural give location) 2018 W. North Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) Margaret Flanigan		4. DATE (Month) (Day) (Year) OF DEATH: October 31, 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 2-28-1871
9. AGE last birthday 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: John Flanigan		14. MOTHER'S MAIDEN NAME: Catherine McGlennon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Arteriosclerotic cardiovascular disease			Years
ANTECEDENT CAUSE (S) (B) Malnutrition			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Dehydration			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7- , 19 53 , to 10-31- , 19 55 that I last saw the deceased alive on 10-31- , 19 55 , and that death occurred at 2:15 PM , from the causes and on the date stated above.			
SIGNATURE Suea Wachler		DATE SIGNED 10-31-55	
ADDRESS Spring Grove State Hospital Catonsville 28, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		DATE THEREOF NOV 3-55	
NAME OF CEMETERY OR CREMATORY UNION MEDICAL SCHOOL		LOCATION (City, town, or county) (State) 29 S. GREEN ST	
DATE REC'D BY LOCAL REGISTRAR 10-31-55		REGISTRAR'S SIGNATURE Victor S. Harris	
24. FUNERAL DIRECTOR Dyfel Bros		ADDRESS 1700 ELMHURST ST	

BUREAU V. S.

NOV 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9447

CERTIFICATE OF DEATH

09435

Reg. Dist. No.

30

Items 3, 13, Film 6157 10/12/55 R

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 24 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) Cathedral and Madison Sts.			
3. NAME OF DECEASED: (First) Charles (Middle) A. (Last) Frannie Frainig				4. DATE (Month) (Day) (Year) OF DEATH: October 7, 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: 8-8-1902	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Keeper Building Construction		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Frannie Frainie				14. MOTHER'S MAIDEN NAME: Margaret Schneider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 331X							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) Cerebrovascular accident							
(B) Cerebral arteriosclerosis							
(C) Generalized arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-13- , 19 55 , to 10-7- , 19 55 , that I last saw the deceased alive on 10-7- , 19 55 , and that death occurred at 4:25PM , from the causes and on the date stated above.							
SIGNATURE Spella Wachter		ADDRESS Spring Grove State Hospital		DATE SIGNED 10-7-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/10/55		NAME OF CEMETERY OR CREMATORY Holy Redeemer		LOCATION (City, town, or county) (State) Baltimore Maryland	
DATE REC'D BY LOCAL REGISTRAR Oct 8 1955		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR H. J. Mears & Son		ADDRESS 805 N. Calvert St.	

THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF PUBLIC HEALTH
DIVISION OF VETERINARY MEDICINE
WASHINGTON, D. C. 20540

OFFICE OF THE VETERINARY MEDICAL DIRECTOR
WASHINGTON, D. C. 20540

MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUMMARY: [Illegible]

DETAILS: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

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6. [Illegible]

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100. [Illegible]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09436

9448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>Sick Feb 24 1955</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> <u>3101.4</u>			
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>2628 Park Heights Terrace</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BERTHA</u> <u>-</u> <u>GARFINKEL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>16</u> <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>VTA Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>VTA</u>	
13. FATHER'S NAME: <u>Abraham Abrams</u>				14. MOTHER'S MAIDEN NAME: <u>Sara</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mr. Harry Garfinkel - 2628 Park Heights Terrace</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Diabetes</u>							
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>							
(C) <u>Chronic Brain Syndrome</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 9th, 1955</u> , to <u>10.16</u> , 1955, that I last saw the deceased alive on <u>10.16</u> , 1955, and that death occurred at <u>8:25p</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u>		M. D. <u>Spring Grove State Hosp.</u>		DATE SIGNED <u>10/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/18/55</u>		NAME OF CEMETERY OR CREMATOR <u>Suburty Masach Ari</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/18/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Sol Gershowitz</u>		ADDRESS <u>1124-2671 North Ave.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09437

9449

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD		LENGTH OF STAY (in this place) 1 DAY		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 305 S. ROBINSON STREET			
3. NAME OF DECEASED: (First) (Middle) (Last) THOMAS A. GARNER SR.				4. DATE OF DEATH: (Month) (Day) (Year) OCTOBER 4 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 1/26/79	9. AGE last birthday 76 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN -Ret. City Police				10B. KIND OF BUSINESS OR INDUSTRY: CITY POLICE		11. BIRTHPLACE (State or foreign country): DANVILLE, VIRGINIA	
13. FATHER'S NAME: ARCHER GARNER				14. MOTHER'S MAIDEN NAME: ELIZABETH YANCY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) YES SAW				16. SOCIAL SECURITY NO. 214-26-7256		17. INFORMANT & ADDRESS: CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DISSECTING ABDOMINAL ANEURYSM							UNKNOWN
ANTECEDENT CAUSE (S) DUE TO ARTERIOSCLEROSIS							UNKNOWN
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CARCINOMA, PROSTATE							3 - 4 YRS.
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from OCT. 3, 1955 , to OCT. 4, 1955 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
SIGNATURE FRANCIS G. DICKEY, Chief Medical Service				ADDRESS M. D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 10-4-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				DATE THEREOF 10-7-55		LOCATION (City, town, or county) (State) OAK LAWN CEMETERY BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-7-55				REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOMES, 4210 BELAIR ROAD BALTIMORE, MD.	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9450

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 09438

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>West Va.</u>	COUNTY <u>Putnam</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Pittsburgh, Ind.</u>	LENGTH OF STAY (in this place) <u>2 wks.</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Wardensville W. Va.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>272 #7 Old Court Rd.</u>		STREET ADDRESS (If rural, give location) <u>85X-3</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>SUSAN</u>	(Middle) <u>REBECCA</u>	(Last) <u>GODLOVE</u>	(Month) <u>Oct</u> (Day) <u>16</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 31, 1892</u>
9. AGE last birthday: <u>83</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home West Va.</u>	
11. BIRTHPLACE (State or foreign country): <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Oscar White</u>		14. MOTHER'S MAIDEN NAME: <u>Marg. Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Marg. Spilman (daughter)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
422.2 Immediate cause (a) <u>Chor. Myocarditis</u>		10 yrs.	
Antecedent cause(s) (b) <u>Chor. Choleocystitis & Lithiasis</u>		3 yrs.	
Diseases or conditions, if any, giving rise to the above cause (c) <u>Arthritis</u>		10-15 yrs.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDING OF OPERATION: <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>None</u>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>D. D. Caples</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>10-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>Oct 19, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>WARDENSVILLE</u>		LOCATION (City, town, or county) (State) <u>WEST VIRGINIA</u>	
24. FUNERAL DIRECTOR <u>Stover Stranburg VA.</u>		ADDRESS	

RECEIVED

OCT 24 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9451

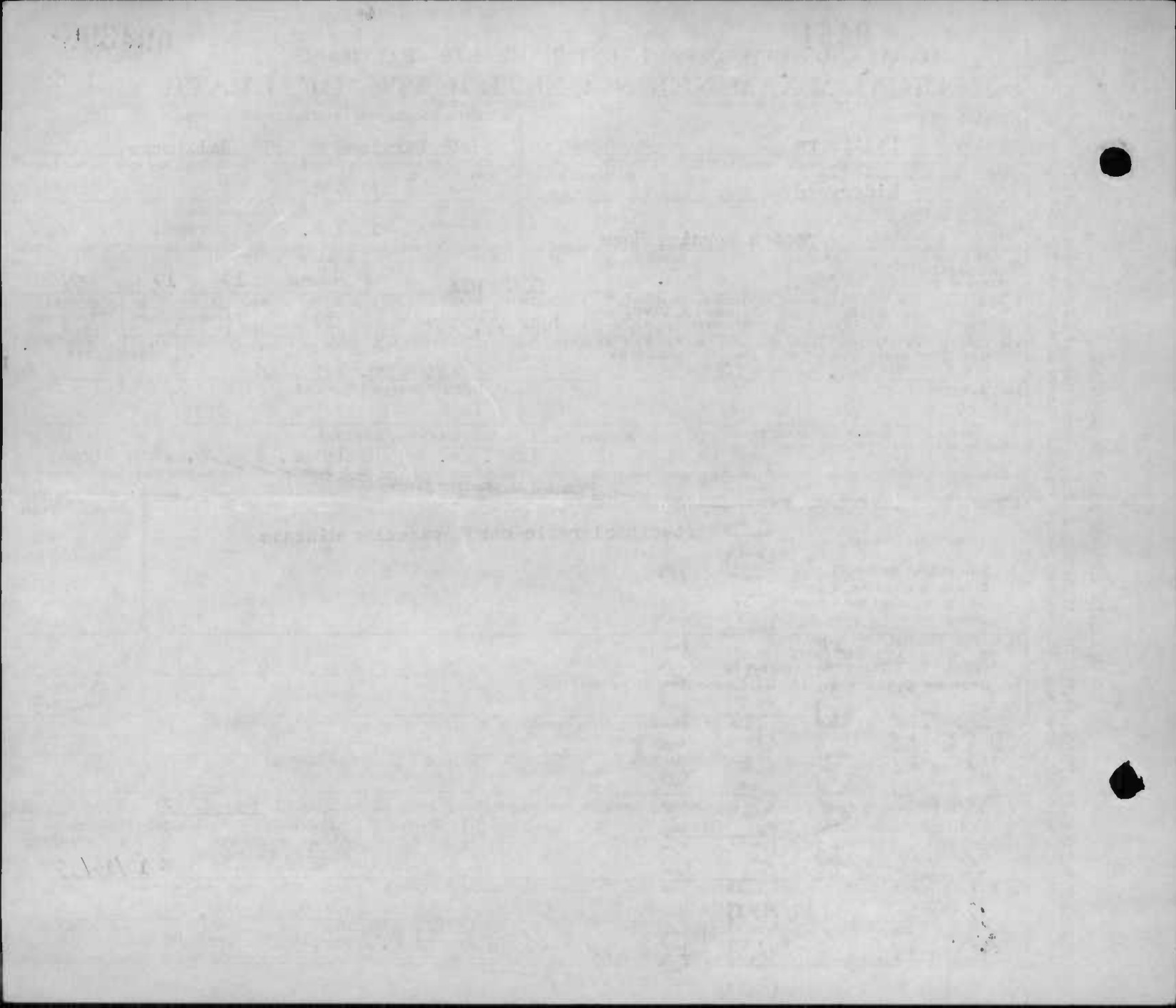
09439
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Riderwood</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u>				STREET ADDRESS (If rural, give location) <u>1521 E. 28th Street</u>			
3. NAME OF DECEASED: (First) <u>JAMES</u> (Middle) <u>D.</u> (Last) <u>GOLDRICK</u>		4. DATE OF DEATH		(Month) <u>10</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>June 27, 1875</u>	9. AGE last birthday: <u>80</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Ret. Loan Office</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Wm. Mc Callister, 1521 E. 28th Street</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>422.1</u> Immediate cause (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating <u>underlying cause last</u> (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Wm. W. Ruck</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/19/55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/22/1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State): <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>10/20/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>Leonard J. Ruck, 5305 Harford Road #14</u>		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09440
Reg. Dist.

No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY BALTO.			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN DUNDALK 22		LENGTH OF STAY (In this place) 3 YRS		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore DUNDALK 22		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave. West of North Point Road				STREET ADDRESS (If rural, give location) 7358 Manchester Road			
3. NAME OF DECEASED: (First) Irvin		(Middle) STEPHEN		(Last) GONSCHOR		4. DATE OF DEATH (Month) (Day) (Year) October 14 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIVORCED		8. DATE OF BIRTH: 17 SEPT 1922		9. AGE last birthday: 33 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): CHECKER		10b. KIND OF BUSINESS OR INDUSTRY: STEEL MFGR		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOHN GONSCHOR				14. MOTHER'S MAIDEN NAME: FELICIA BURAZZINSKI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		(If Yes, give war or dates of service) —		16. SOCIAL SECURITY No.: 214-16-9684		17. INFORMANT & ADDRESS: FELICIA GONSCHOR - SAME ADDRESS	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Hemoperitoneum secondary to Ruptured Spleen Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street)		21c. (City or town) (County) 03 Baltimore (State) Maryland			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Speeding auto - out of control			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Miller		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		DATE SIGNED 10/14/55	
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF 10-18-55		NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY		LOCATION (City, town, or county) (State) BALTO. CO., MD.	
DATE REC'D BY LOCAL REG. 10/17/55		REGISTRAR'S SIGNATURE Edith Harley		24. FUNERAL DIRECTOR Walter Burke Bradley		ADDRESS Dundalk, Md.	

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OCT 18 1935

BUREAU V. 3

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09441

9379

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>		LENGTH OF STAY (in this place) <u>22 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 VENTNOR TERRACE</u>				STREET ADDRESS (If rural give location) <u>133 VENTNOR TERRACE</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANKLIN HARRISON GRAMMER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10-28-1953</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>OCT. 17, 1891</u>	
9. AGE last birthday <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREFIGHTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL PLANT</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEO. W. GRAMMER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE E. EBBERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-16-5115</u>		17. INFORMANT & ADDRESS <u>VELMA ABBRECHT - SAME</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
162X IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CA.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-24, 1953, to 10-28, 1953, that I last saw the deceased alive on 10-28-1953, and that death occurred at 11:55 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Coch O'Brien</u>				ADDRESS (Street, city, town, state) <u>M.D. 2 Kinship Rd Balt 22</u>			
				DATE SIGNED <u>10-30-53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>BT. PAULS</u>		LOCATION (City, town, or county) (State) <u>MATTHEWS, VA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William M. Hoyle</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wendley, Wendley, Md.</u>		ADDRESS	
DATE <u>Oct 30-1953</u>							

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **09442**

9452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryla		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 19 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove Hospital				STREET ADDRESS (If rural give location) 3406 Keene Avenue ✓			
3. NAME OF DECEASED: ANNA (First) BLANCHE (Middle) GREEN (Last)				4. DATE (Month) (Day) (Year) DEATH: 10 4 19 55			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: 10-25-1868	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: (?) Noely				14. MOTHER'S MAIDEN NAME: (?) Coggins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Harvey Green 5318 Plymouth Rd. Balto, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 450.0 Generalized Arteriosclerosis							
ANTECEDENT CAUSE (B) Senile Psychosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 1903.71 (C) Malnutrition and Dehydration							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? Catonsville Maryland 03			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY June 27, 1955 M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Slipped and fell			
22. I hereby certify that I attended the deceased from June 17, 1936 to Oct 4 , 19 55 , that I last saw the deceased alive on Oct 4 , 19 55 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. SIGNATURE [Signature] ADDRESS [Signature] DATE SIGNED 10/4/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE OF BURIAL 10/6/55		NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		LOCATION (City, town, or county) (State) BALTO, Md.	
DATE REC'D BY LOCAL REGISTRAR 10/5/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Varford Rd.	

10-1-52

STATE DEPARTMENT OF HEALTH - BALTIMORE

DEATH CERTIFICATE

10-1-52

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF MARRIAGE: [illegible]

NAME OF SPOUSE: [illegible]

DATE OF DEATH OF SPOUSE: [illegible]

NAME OF CHILDREN: [illegible]

DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

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DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

DATE OF BIRTH OF CHILDREN: [illegible]

NAME OF CHILDREN: [illegible]

9453

09443

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville	LENGTH OF STAY (in this place) 8yr.2mos.27days	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore	3Y01-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural, give location) 1628 N. Durham Street	
3. NAME OF DECEASED: (First) (Middle) (Last) Robert Griffin		4. DATE OF DEATH (Month) (Day) (Year) October 27, 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 8-19-1871
9. AGE last birthday: 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Plasterer		10b. KIND OF BUSINESS OR INDUSTRY: Contractor	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Charles Griffin	
14. MOTHER'S MAIDEN NAME: Susan Bill		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) Acute cardiac failure DUE TO			
Antecedent cause(s) (b) Arteriosclerotic heart disease Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c) Generalized arteriosclerosis			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>John M. Kieffer</i>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. 10-27-55	
23. BURIAL, CREMATION, REMOVAL (Specify): burial	DATE THEREOF 10/31/55	NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
LOCATION (City, town, or county) (State) Baltimore, Maryland	24. FUNERAL DIRECTOR Wm. Book, Jr., 1217 St. Paul Street		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09444

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CERTIFICATE OF DEATH

Reg. Dist. No. *45*

1. PLACE OF DEATH- COUNTY <i>BALTIMORE</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MARYLAND</i> COUNTY <i>1st</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Middle River</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>54</i>	
TOWN <i>Middle River</i>		TOWN <i>Middle River</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>At Home</i>		STREET ADDRESS (If rural, give location) <i>814 WAMPLER Rd</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>JAMES</i>	(Middle) <i>STANISLAUS</i>	(Last) <i>GRUSZ</i>
4. DATE OF DEATH	(Month) <i>OCT</i>	(Day) <i>8</i>	(Year) <i>1953</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>Nov-26-1887</i>
9. AGE last birthday <i>67</i> yrs.	If under 1 year Months	If under 24 hrs. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>EASTERN ROLLING-MILL</i>	
11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>POLAND</i>	
13. FATHER'S NAME <i>JOSEPH GRUSZ</i>		14. MOTHER'S MAIDEN NAME <i>MARY UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>216-10-0743</i>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <i>ANNA J GRUSZ 814 WAMPLER Rd</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
Immediate cause

(a) *Arterio-sclerotic Cardio-vascular Disease*

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) *Arterio-sclerotic Gangrene of Foot*

2 mo.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *July 1st*, 1953, to *Oct 8*, 1953, that I last saw the deceased alive on *Oct 8*, 1953, and that death occurred at *3:00* A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>BURIAL</i>	<i>OCT 11-1953</i>	<i>ST. STANISLAUS</i>	<i>1300 DUNDALK AVE</i>	<i>BALTIMORE</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>10-10-53</i>		<i>George A. Weber</i>	<i>705 S. Ann St</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

CERTIFICATE OF DEATH

Reg. Dist. No. 20

9455

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>				OR TOWN <u>Catonsville</u> 52			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 Oella Ave.</u>				STREET ADDRESS (If rural give location) <u>109 Oella Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>JOHN</u> <u>M.</u> <u>HAHN</u>				OF DEATH: <u>Oct.</u> <u>25,</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 Hrs.
<u>male</u>	<u>white</u>	<u>married</u>	<u>Dec. 4, 1894</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Electrician</u>		<u>Construction</u>		<u>Md.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Edward Hahn</u>				<u>Adda Ott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>yes</u> (If Yes, give war or dates of service) <u>World War I</u>		<u>214-05-8856</u>		<u>Catonsville, Md.</u> <u>Mrs. Marian A. Hahn - 109 Oella Ave.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
196X IMMEDIATE CAUSE (A) <u>Cerebral Embolism</u>							<u>1 day.</u>
ANTECEDENT CAUSE (S): (B) <u>Metastatic Adenoma 2nd L. Ventricle</u>							<u>6 mos.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>10-13</u> , 19 <u>55</u> , to <u>10-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Milank K. Gallagher</u>		<u>M.D. Catonsville, Md.</u>		<u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/28/55</u>		<u>Loudon Park</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/30/55</u>		<u>A. W. Hedrick</u>		<u>Thm. J. Dickener & Sons</u>		<u>Balto 17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO
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1215 EAST 58TH STREET
CHICAGO, ILL. 60637
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FAX 733-8328
WWW.CHICAGO.EDU

9456

CERTIFICATE OF DEATH

Reg. Dist. No.

09446

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 5yrs 10mos 9days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LaPlata 08X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) Francis P. Hamilton				4. DATE (Month) (Day) (Year) OF DEATH: October 11 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 6-1884	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY: farming		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Hamilton				14. MOTHER'S MAIDEN NAME: Catherine C. Dyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.1							
(A) DUE TO Myocardial Infarction						Approx. week 3	
ANTECEDENT CAUSE (B) DUE TO Coronary arteriosclerosis						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Generalized arteriosclerosis						Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Multiple pulmonary abscesses						Years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7- , 19 53 to 10-11- , 19 55 that I last saw the deceased alive on 10-11- , 19 55 , and that death occurred at 8:00A M. from the causes and on the date stated above.							
SIGNATURE Marie Frances Woodward		ADDRESS Spring Grove State Hospital		DATE SIGNED 10-11-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 10-14-55		NAME OF CEMETERY OR CREMATORY St Ignace Cemetery		LOCATION (City, town, or county) Bel Alton Md	
DATE REC'D BY LOCAL REGISTRAR 10-13-55		REGISTRAR'S SIGNATURE M. D. Woodward		24. FUNERAL DIRECTOR The Hunt Funeral Home		ADDRESS Watery Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DECLARATION OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

OCT 18 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-10-53

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY: <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto Coun.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town): TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Becweysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) (Hare) <u>Dora</u> <u>A.</u> <u>Howe</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>30</u> <u>1955</u>	
5. SEX: <u>Fem.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>6-19-63</u>
9. AGE last birthday: <u>92</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>BALTO. CO.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Solomon Wolfgang</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Garrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Marie Menzley, 5214 Midwood Ave</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>450.0</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-17</u> , 19 <u>54</u> , to <u>10-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-30</u> , 19 <u>55</u> , and that death occurred at <u>11:59</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Rena Becker</u>		ADDRESS <u>Spring Grove Hospital</u>	
DATE SIGNED <u>10/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-2-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Forrest Baptist</u>		LOCATION (City, town, or county) (State) <u>Hereford Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/31/55</u>		REGISTRAR'S SIGNATURE <u>Wm. H. H. H. H.</u>	
24. FUNERAL DIRECTOR <u>Wm. H. H. H. H.</u>		ADDRESS <u>Cook Inc. 1217 St Paul St.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

09448

9458

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>CUB HILL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUB HILL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9947 HARFORD ROAD</u>		STREET ADDRESS (If rural, give location) <u>9947 HARFORD ROAD</u>	
3. NAME OF DECEASED (First) <u>EMILY</u> (Middle) <u>CLIFTON</u> (Last) <u>HARRISON</u>	4. DATE OF DEATH <u>OCT. 20,</u> 19 <u>88</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>SEPT. 26, 1888</u>
9. AGE last birthday <u>67</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK SECRETARY - RETIRED</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY TUCKER HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>MARION JENIFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>FAMILY RECORDS</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>420.1 Coronary Occlusion Sudden</u>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Charles F. Donnell</u> (Degree or title)		DATE SIGNED <u>10/20/88</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>OCT. 24, 1988</u>	
NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>		LOCATION (City, town, or county) <u>TOWSON, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>John Burke</u>		ADDRESS <u>Towson, Md.</u>	
DATE REC'D BY LOCAL REG. <u>10/25/88</u>		REGISTRAR'S SIGNATURE <u>G. M. Bacon</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 27 1955

BUREAU V. S.

RECEIVED

9459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	LENGTH OF STAY (in this place) <u>LIFE</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
TOWN <u>PIKESVILLE</u>		TOWN <u>PIKESVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Old Court Rd</u>		STREET ADDRESS (If rural give location) <u>100 Old Court Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>NELLIE</u>	(Middle) <u>E.</u>	(Last) <u>HAYES</u>	(Month) <u>10</u> (Day) <u>27</u> (Year) <u>1955</u>
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>		8. DATE OF BIRTH: <u>DEC 24 1870</u>	
9. AGE last birthday <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>LEWIS NELSON ELSE ROAD</u>		14. MOTHER'S MAIDEN NAME: <u>CAROLINE HIBENNY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>EMMA C. ELSE ROAD - 100 Old Court</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		<u>1 month</u>
ANTECEDENT CAUSE (S) <u>Due to</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Art. Sclerosis</u>		<u>5 yrs.</u>
(C) <u>Hypertension</u>		<u>5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan</u> , 195 <u>0</u> to <u>Oct 27</u> , 195 <u>5</u> , that I last saw the deceased alive on <u>Oct 26</u> , 195 <u>5</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.		
SIGNATURE <u>James H. Miller, M.D.</u>		DATE SIGNED <u>Oct 27, 1955</u>
ADDRESS <u>Pikesville, Md.</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>10/29/55</u>	<u>Gravel Ridge</u>
LOCATION (City, town, or county) (State)		
<u>Pikesville, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>Oct 29, 1955</u>	<u>Do Colby G. Newell</u>	<u>Frank H. Newell - Pikesville, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09450

9380

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22	
TOWN DUNDALK 22		TOWN DUNDALK 22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1720 PINEWOOD RD.		STREET ADDRESS (If rural, give location) 1720 PINEWOOD RD.	
3. NAME OF DECEASED (Type or Print)	(First) CHARLOTTE	(Middle) -	(Last) HEFRIGHT
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 2, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE last birthday 44 yrs.
13. FATHER'S NAME JOHN VAN HOOGE		14. MOTHER'S MAIDEN NAME KATHARINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 272-16-4019	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS RICHARD K. HEFRIGHT - SAME ADDRESS	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X Immediate cause (a) The Cerebro-Vascular Hemorrhage		48 hrs
Antecedent cause(s) (b) Hypertension		20 yrs
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-12, 1955, to 10-10, 1955, that I last saw the deceased alive on 10-9, 1955, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 10-13-55	NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL	LOCATION (City, town, or county) BELAIR, MD.	(State)
DATE REC'D BY LOCAL REG. 10-12-1955		REGISTRAR'S SIGNATURE William M. Kelly		24. FUNERAL DIRECTOR Walter Clark Brady, Dundalk, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OCT 13 1955

BUREAU V. 8

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9391

09451

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
51 TOWN <u>Lundown</u>				TOWN <u>Therburne</u>		02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Palapen River</u>				STREET ADDRESS (If rural, give location)			
<u>Arundel Sand co</u>				<u>1121 Armistead Pl</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John William Heiser Sr</u>				<u>Oct 28</u> 19 <u>53</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Sept 15 1903</u>	9. AGE last birthday: <u>52</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?		
<u>unemployed Coal Miner</u>		<u>Coal Miner</u>		<u>Penn</u>	<u>US</u>		
13. FATHER'S NAME: <u>John Heiser</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Burke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>205 05 6079</u>		17. INFORMANT & ADDRESS: <u>1121</u> <u>Mrs Heiser Armistead Pl</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Cornray Phos Phos</u>							
DUE TO							
Antecedent cause(s) (b) <u></u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John W. Kieffer</u>		1010 Leaden		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Oct 29 1953</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>11-1-53</u>		NAME OF CEMETERY OR CREMATORY: <u>Shyrwin</u>		LOCATION (City, town, or county) (State): <u>Anniston Pa</u>	
DATE REC'D BY LOCAL REG. <u>Oct 29 53</u>		REGISTRAR'S SIGNATURE: <u>John W. Kieffer</u>		24. FUNERAL DIRECTOR: <u>Howard H. Hubbard</u>		ADDRESS: <u>4107</u> <u>Belknap Ave</u>	

BUREAU V. S.

OCT 31 1955

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09452

9460

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
X <u>Fort Howard</u>		<u>24 Days</u>		<u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2016 Hunter Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOHN W. HICKS</u>				<u>October 28 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Divorced</u>	<u>12-25-99</u>	<u>55</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Hicks</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>			
15a. (If Yes, give year or dates of service) <u>WW I</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>443X HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 4</u> , 19 <u>55</u> , to <u>Oct. 28</u> , 19 <u>55</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegriest, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Larber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders Funeral Home, 217 E. Preston Street, Baltimore, Md.</u>			

CERTIFICATE OF DEATH

Reg. Form No. 10

Death certificate to be filled out by the physician or other qualified person

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF DECEASED: [illegible]

TESTIFYING PHYSICIAN: [illegible]
TESTIFYING SURGEON: [illegible]

TESTIFYING NURSE: [illegible]
TESTIFYING CLERK: [illegible]

TESTIFYING CHURCH CLERK: [illegible]
TESTIFYING MINISTER: [illegible]

TESTIFYING JUDGE: [illegible]
TESTIFYING SHERIFF: [illegible]

TESTIFYING CORONER: [illegible]
TESTIFYING JURY: [illegible]

TESTIFYING OTHER: [illegible]

BUREAU V. S.

NOV 2 1955

RECEIVED

CERTIFICATE OF DEATH

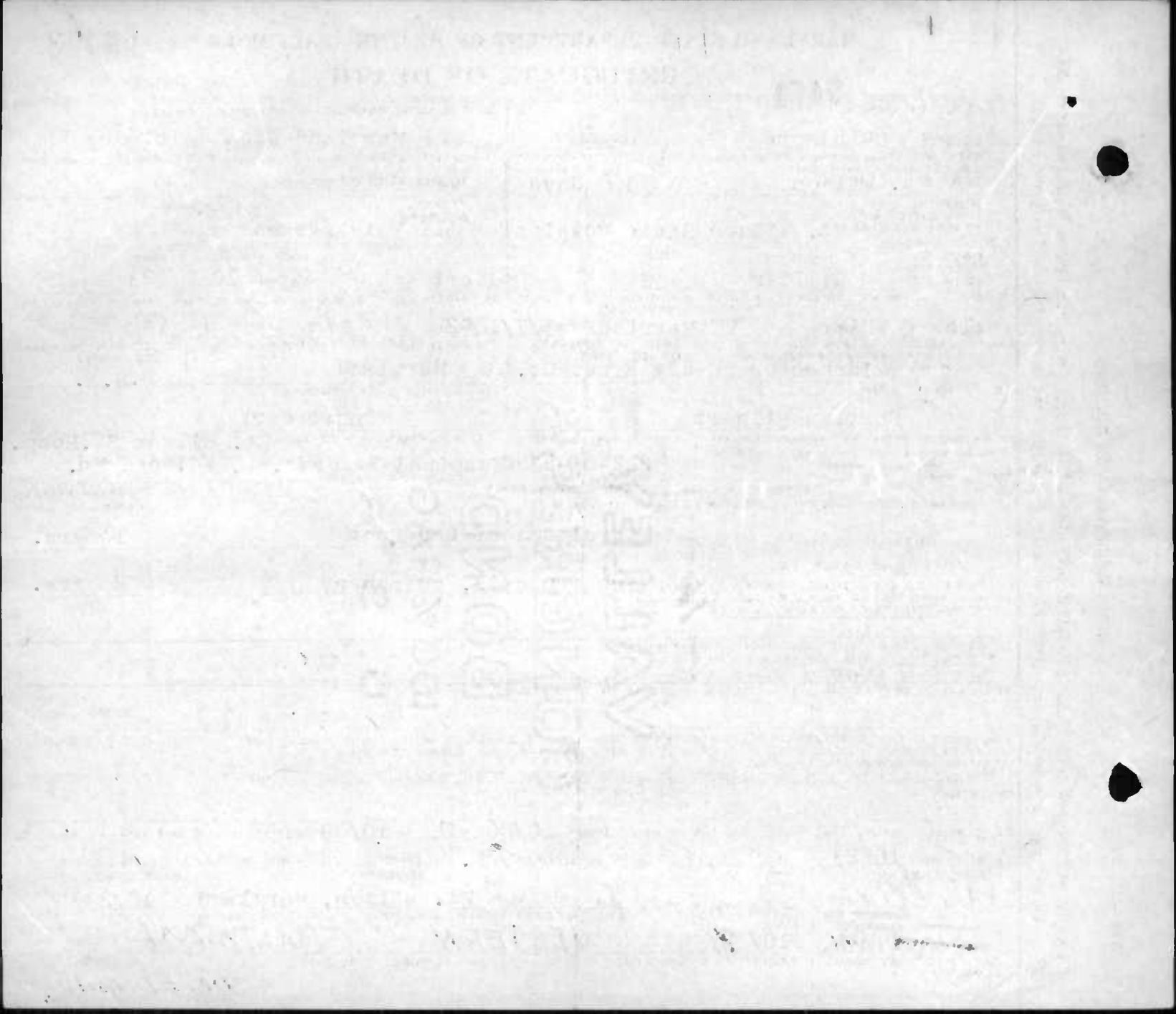
Reg. Dist. No. 32

9461

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 29</u> <u>3Y01-4</u>			
X <u>Mt. Wilson</u>		<u>368 days</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>511 Yale Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>William J Hilbert</u>				OF DEATH: <u>10</u> <u>23</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>5/7/1892</u>	<u>63</u> yrs.	<u>4</u> Months	<u>16</u> Days	<u></u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Inspector Gas & Elec. Co.</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Charles Hilbert</u>				14. MOTHER'S MAIDEN NAME: <u>Minnie Carl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-05-4380</u>		17. INFORMANT & ADDRESS: <u>Mt. Wilson St. Hosp. Hospital Records, Mt. Wilson, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of the Lung</u>						<u>1½ yrs.</u>	
ANTECEDENT CAUSE (B) <u>Tuberculosis, pulmonary</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>002X</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/20, 1954</u> , to <u>10/23, 1955</u> , that I last saw the deceased alive on <u>10/23, 1955</u> , and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Newman</u>		ADDRESS <u>M. D. Mt. Wilson, Maryland</u>		DATE SIGNED <u>10/23/55</u>			
23. BURIAL, CREMATION, REMOVAL, ETC. <u>BURIAL</u>		DATE THEREOF <u>10/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		LOCATION (City, town, or county) (State) <u>BALTO. M.D.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS <u>4101 EDMONDSON AVE.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ESSEX</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ESSEX</u>		54	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>719 S MARLYN AVE</u>				STREET ADDRESS <u>719 S MARLYN AVE</u>		(If rural give location) 1	
3. NAME OF DECEASED: (Type or Print) <u>William</u>		(First) (Middle) (Last) <u>Hildebrandt</u>		4. DATE OF DEATH: <u>OCT. 3</u>		(Month) (Day) (Year) <u>19 55</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>OCT. 23-1884</u>	9. AGE last birthday: <u>70</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>IRON MOLDER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>BETH STEEL</u>		11. BIRTHPLACE (State or foreign country): <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOHN HILDEBRANDT</u>				14. MOTHER'S MAIDEN NAME: <u>ANNA KOENIG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>LENA E HILDEBRANDT</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
422.1 Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.						(a) <u>Cerebral apoplexy.</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c)	
						<u>Sudden</u> <u>2 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <u>OCT 2, 1955</u> , to <u>OCT 3, 1955</u> , that I last saw the deceased alive on <u>OCT 3, 1955</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Gardner M.D.</u>		DATE THEREOF <u>10/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>10/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-5-55</u>		REGISTRAR'S SIGNATURE <u>John B. Connelly</u>		24. FUNERAL DIRECTOR <u>John B. Connelly</u>		ADDRESS <u>Essex 21</u> <u>md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9453

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PARK HALL</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52</u> <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>7/4/55 to 10/11/55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Park Hall</u> <u>18x-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>SPRING GROVE STATE HOSP</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MINNIE WOOD HILL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>11</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>11-2-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NURSE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>RICHARD H. WOOD</u>				14. MOTHER'S MAIDEN NAME: <u>JEMIMA WOOD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>ALLAN</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
581.0 IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u>							
ANTECEDENT CAUSE (S): (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4</u> , 19 <u>55</u> , to <u>10/12</u> , 19 <u>55</u> that I last saw the deceased alive on <u>July 4</u> , 19 <u>55</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>		ADDRESS <u>M.D. Spring Grove St. Hosp.</u>		DATE SIGNED <u>10/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Andrews</u>		LOCATION (City, town, or county) (State) <u>Leonardtown</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/12/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Joe C. Mattingly</u>		ADDRESS <u>Leonardtown</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 14 1955

RECEIVED

Item 21 Film G188 11-9-55 am

CERTIFICATE OF DEATH

Reg. Dist. No. 38

9464

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ruxton</u>				OR TOWN <u>Ruxton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Avenue</u>				STREET ADDRESS (If rural give location) <u>Maple Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>JULIA ANN HOOK</u>				OF DEATH: <u>OCT. 29 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>June 10, 1867</u>	
				9. AGE last birthday <u>88</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Eli Scott Bond</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
14. MOTHER'S MAIDEN NAME: <u>Elizabeth Ann Rowe</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Family Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A)		INTERVAL BETWEEN ONSET AND DEATH			
903.0		Pneumonia Embolism		Sudden			
ANTECEDENT CAUSE (S)		(B)		7 Days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(C)					
		Fractured Left Hip					
		General Arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardio-Renal Vascular Disease 15 yrs</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Bedroom</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Balto. Md.</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 22 55 8P.M.</u>				21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>Fell while walking around bed.</u>	
22. I hereby certify that I attended the deceased from <u>No</u> , 19 <u>55</u> , to <u>Oct 28, 1955</u> that I last saw the deceased alive on <u>October 18, 1955</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Donnell</u>				ADDRESS <u>7501 York Rd #4md</u>		DATE SIGNED <u>10/31/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Oct. 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>				24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 31, 1955</u>				REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.
NOV 1 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9465

CERTIFICATE OF DEATH

09457

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>39 Days</u>		OR TOWN <u>Baltimore</u>		TOWN <u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1837 E. Lombard Street</u>			
3. NAME OF DECEASED (Type or Print) <u>MIKE</u> (First) <u>HORTON</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>9/8/96</u>	
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tug boat worker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Harry Horton</u>				14. MOTHER'S MAIDEN NAME <u>Catherine MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-07-2447</u>		17. INFORMANT & ADDRESS <u>Clin.Rec.Vet.Adm.Hosp., Ft.Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>154X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA OF RECTUM</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7-8-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Exploratory Laparotomy & sigmoid colostomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> et work <input type="checkbox"/> Not white et work <input type="checkbox"/>		21e. INJURY OCCURRED White et work <input type="checkbox"/> Not white et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 15, 1955</u> , to <u>October 24, 1955</u> , that he was the deceased <u>at the time of death</u> <u>and that death occurred at</u> <u>10:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey, M.D. Chief, Medical Service VAH, FORT HOWARD, MARYLAND</u>				DATE SIGNED <u>10-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>OCT 28 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Jawson L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> <u>6009 Harford Rd., Balto, Md.</u>			

DEATH CERTIFICATE

Rev. Oct. 1937

1. DEATH REGISTRATION NUMBER OF DECEASED

2. PLACE OF BIRTH

3. SEX
4. COLOR
5. RACE

6. MARITAL STATUS
7. OCCUPATION

8. DATE OF BIRTH
9. PLACE OF BIRTH

10. DATE OF DEATH
11. PLACE OF DEATH

12. TIME OF DEATH
13. CAUSE OF DEATH

14. MANNER OF DEATH
15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESS
17. SIGNATURE OF DECEASED

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BUREAU V. 2

OCT 21 1937

RECEIVED

9466

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Crofton</u>		TOWN <u>Baltimore</u>	<u>3V01-4</u>
HOSPITAL OR INSTITUTION OR Sorensen Nursing Home		STREET ADDRESS (If rural give location)	
90 STREET ADDRESS <u>7912 Ruxton Rd.</u>		<u>424 Whitridge Ave.</u>	

3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First)	(Middle)	(Last)	OF DEATH: <u>Oct. 4, 1955</u>		
(Type or Print) <u>ANNA MAY FISHER HULL</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. IF UNDER 1 YEAR
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Aug. 26, 1875</u>	<u>80</u> yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>rtd Practical Nurse - self Emp.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Mass.</u>		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		

13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Lucien Fisher</u>		<u>Celia A. Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>no</u>	
17. INFORMANT & ADDRESS:		<u>Mr. Harry W. Rohr - 4019 Roland Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Pulmonary Embolus.</u>		<u>6 hours.</u>
ANTECEDENT CAUSE (B) <u>Malignancy Intestine.</u>		<u>Several years.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>metastasis of malignancy.</u>		<u>Gradual.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1955, to Oct. 4, 1955, that I last saw the deceased alive on Oct. 2, 1955, and that death occurred at 6 P. M. from the causes and on the date stated above.

SIGNATURE James Graham Marston. ADDRESS 516 Central St. DATE SIGNED Oct. 5, 1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/5/55</u>	<u>Central Cem.</u>	<u>Millbury, Mass.</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>10/5/55</u>	<u>Dr. H. H. H. H.</u>	<u>Wm. J. Liskner & Sons - Balto.</u>	<u>17 Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9467

CERTIFICATE OF DEATH

09459

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>150 Days</u>		TOWN <u>Newcomb</u>		<u>20X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O. Box</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>OTIS B. HUNT</u>				<u>October 29 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>2-1-94</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Woodworker</u>		<u>Woodwork Co.</u>		<u>Royal Oak, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Rose Leonard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WW-I</u>				<u>116-10-6642</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>ACUTE NEPHROSIS RIGHT KIDNEY</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)						<u>UNKNOWN</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7/18/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>NEPHRECTOMY FOR TUBERCULOSIS</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>55</u> , to <u>October 29</u> , 19 <u>55</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bristol Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bristol, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>10/31/55</u>		REGISTRAR'S SIGNATURE <u>Ramson L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G.L. Schwab</u>		ADDRESS <u>2101 Frederick Ave., Balto., Md.</u>	

CERTIFICATE OF DEATH

Form 100-1

TO BE FILLED BY THE REGISTRAR OF DEATHS

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. PLACE OF BIRTH		14. OCCUPATION		15. EDUCATION	
16. MARITAL STATUS		17. RELIGION		18. RACE	
19. SOCIAL CLASS		20. INCOME		21. HEALTH	
22. PREVIOUS ILLNESS		23. MEDICAL TREATMENT		24. SURVIVAL	
25. OTHER FACTORS		26. SIGNATURE		27. DATE	

RECEIVED
BUREAU A. S.
OCT 31 1955
OCT 31 1955
OCT 31 1955

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
RECEIVED
OCT 31 1955
OCT 31 1955
OCT 31 1955

9469

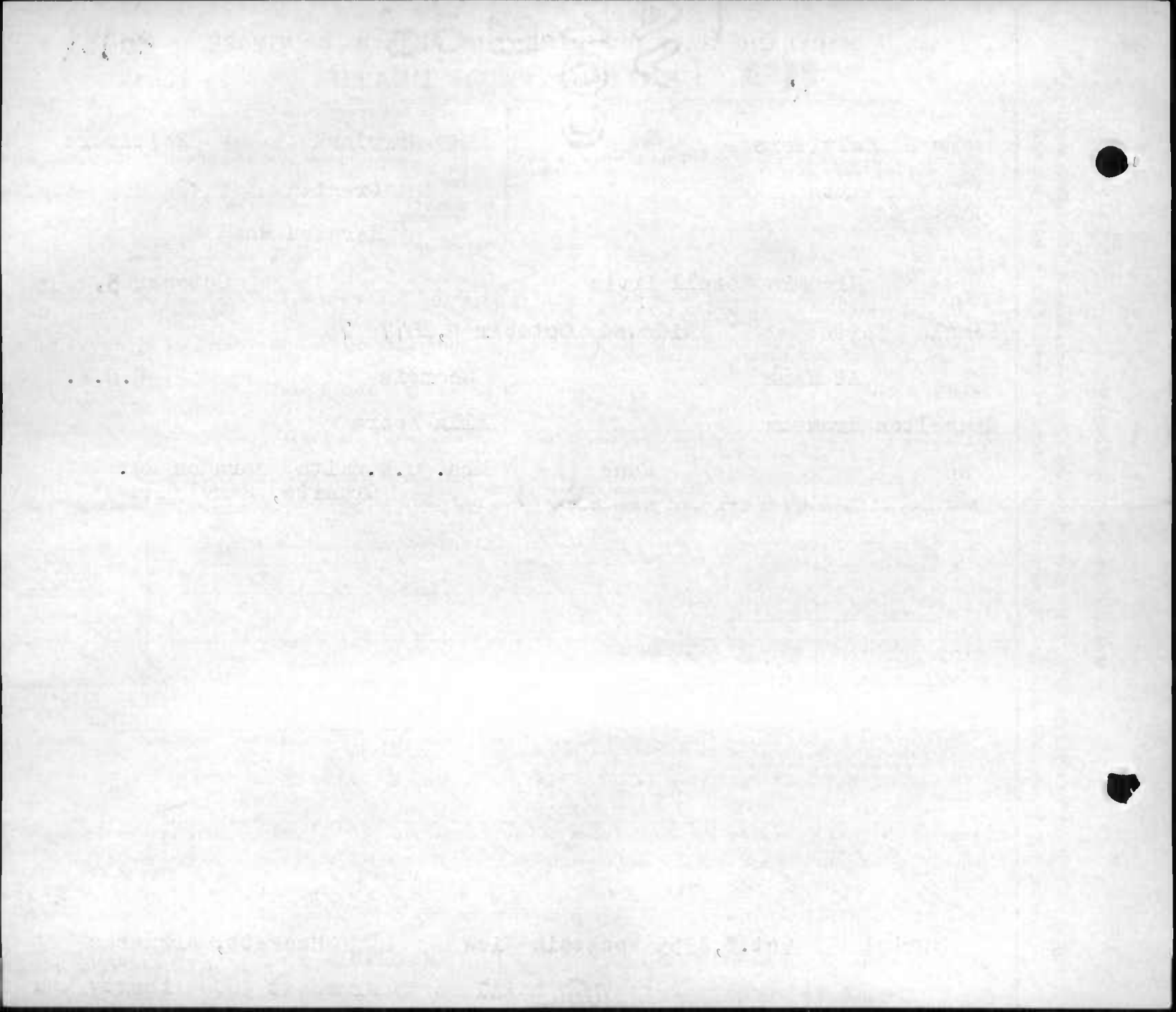
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Granite</u>				TOWN <u>Granite</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				<u>Herndon Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>Clemmie Mozell Irvin</u>				4. DATE OF DEATH: <u>October 3, 1955</u>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>October 2, 1877</u>	
				9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Singelton Branson</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. O.B. Smith Herndon Rd. Granite, Maryland</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X							
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				1 day			
ANTECEDENT CAUSE (S) <u>Hypertensive C.V. Disease -</u>				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>JUNE 1, 1955</u> , to <u>OCT 3, 1955</u> , that I last saw the deceased alive on <u>OCT 3, 1955</u> , and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS <u>M.D. 3601 Upland Rd</u>		DATE SIGNED <u>Oct 10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Oct. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>	
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>				LOCATION (City, town, or county) <u>Hackett, Arkansas</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>10-4-55</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>4600 Liberty Hgt</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

09462

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH - COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>GLEN ARM</u>		LENGTH OF STAY (in this place) <u>30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ARM</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GLEN ARM, MD</u>				STREET ADDRESS (If rural, give location) <u>/</u>	
3. NAME OF DECEASED (Type or Print) <u>GLENIOUS C. JACKSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 8 1953</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 18, 1896</u>	9. AGE last birthday <u>59</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTORS</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
13. FATHER'S NAME <u>LATNER JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>ESTHER JACKSON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218053216</u>		17. INFORMANT AND ADDRESS <u>ANNA JACKSON - GLEN ARM, MD</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 9, 1934, to Oct. 8, 1953, that I last saw the deceasedalive on Oct 8, 1953, and that death occurred at 4 P.M. m., from the causes and on the date stated above.SIGNATURE: Alford F. Hudson, M.D.

(Degree or title)

ADDRESS: 1701 McCall StDATE SIGNED: 10/9/53

23. BURIAL, CREMATION (REMOVAL) (Specify)

DATE THEREOF 10/12/53NAME OF CEMETERY OR CREMATORY MT. ZIONLOCATION (City, town, or county) LUNCREE, MD

(State)

DATE REC'D BY LOCAL REG. 10-10-53REGISTRAR'S SIGNATURE /

24. FUNERAL DIRECTOR

ADDRESS

Wm. J. Hatman, Jr. 1701 McCall St BALTO. MD

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

41414

RECEIVED

1941

1941



MARYLAND

STATE DEPARTMENT OF HEALTH

9471

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2831 Summitt Avenue		STREET ADDRESS (If rural, give location) 2831 Summitt Avenue	
3. NAME OF DECEASED (First) Mrs. Alice (Middle) E. (Last) Jager		4. DATE OF DEATH (Month) October (Day) 19th (Year) 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Oct. 10, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eckhardt		14. MOTHER'S MAIDEN NAME Frances Higgins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. George Claybaugh, 2610 Evergreen Ave #14			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
434.3 Immediate cause (a) Pneumonitis				6 days	
Antecedent cause(s) (b) Generalized debilitation					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cardiac decompensation					
11. OTHER SIGNIFICANT CONDITIONS		1 1/2 Old hemiplegia due to Cerebral Hemorrhage			
19a. DATE OF OPERATION No		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct. 19, 1954, to Oct. 20, 1955, that I last saw the deceased alive on Oct. 19, 1955, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

SIGNATURE Frank G. Ruck, Jr.		ADDRESS 9005 Harford Rd		DATE SIGNED 10/20/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 22, 1955	NAME OF CEMETERY OR CREMATORY Moreland Mem Park	LOCATION (City, town, or county) Baltimore, Maryland	(State)	
DATE REC'D BY LOCAL REG. 10/20/55	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14		ADDRESS	

MARGIN RESERVED FOR BINDING

Dr. Kasik
9005 Harford Road
NO 5 8692

8:30 To 9:30

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9472

CERTIFICATE OF DEATH

Reg. Dist. No.

09464

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Balto.	STATE	Md.
CITY (If outside corporate limits, write RURAL and give nearest town)	Lutherville	COUNTY	Balt.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	College Manor	CITY (If outside corporate limits, write RURAL and give nearest town)	Balto.
		STREET ADDRESS	603 Murdock Rd.
3. NAME OF DECEASED:	(First) JOHN	(Middle) COVINGTON	(Last) JETT
4. DATE OF DEATH:	Oct. 19, 1955		
5. SEX:	male	6. COLOR OR RACE:	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	widowed	8. DATE OF BIRTH:	July 1, 1865
9. AGE last birthday	90 yrs.	IF UNDER 1 YEAR	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	rtd Gen. Agt.	10B. KIND OF BUSINESS OR INDUSTRY:	Fire Insurance
11. BIRTHPLACE (State or foreign country):	Virginia	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:	Robert E. Jett	14. MOTHER'S MAIDEN NAME:	Sarah A. Covington
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	none
17. INFORMANT & ADDRESS:	Mr. Ewell K. Jett - 4546 N. Charles St.		
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)			6 days
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April, 1955, to Oct 19, 1955, that I last saw the deceased alive on October 18, 1955, and that death occurred at 4:45 AM, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
A. Allan Linn		M. D. 4408 Rockaway Blvd	Oct. 19, 1955
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/21/55	Druid Ridge Cem.	Pikesville, Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-29-55	[Signature]	Wm. J. Pickner & Sons	Balto 17, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

9473

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Lutherville</u>		3 yrs.		TOWN <u>500 Bosley Avenue 55</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>				STREET ADDRESS (If rural give location) <u>Towson</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
MINNIE JOHNSON				October 28, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Female	White	Widow	February 25, 1866	89			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Salamanca, N.Y.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William T. Fish				Mary Jeanette Brace			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No None				None		Hospital Records	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE				(A) Generalized arteriosclerosis			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from 8/2, 1955, to 10/28, 1955, that I last saw the deceased alive on 9/16, 1955, and that death occurred at 1:25 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Madeline C. Scowinski</u>				ADDRESS <u>170 W. Penna. Ave. Towson Md.</u>		DATE SIGNED <u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Oct. 29, 1955		Hunt Co. Funeral Home		Salamanca, N.Y.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct. 29, 1955		Madeline C. Gray		John Burns Sons		Towson, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11-1-55

CERTIFICATE OF DEATH

0-73

BUREAU V. S.

NOV 1 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09466

2411 N. Charles Street, Baltimore

9474

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH: COUNTY <u>Ba 1 to</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Ba 1 to</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ba 1 to 14</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ba 1 to 14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3136 Acton Rd</u>		STREET ADDRESS (If rural, give location) <u>3136- Acton Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Hermine E Joiner</u>		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 15-1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Custom Service</u>	9. AGE last birthday <u>46</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Pfeiler</u>		14. MOTHER'S MAIDEN NAME <u>Hermine Stumpf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>215-01-1428</u>	
17. INFORMANT AND ADDRESS <u>Mr Verron W Joiner 3136 Acton Rd</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause(a) Ruptured aortic aneurysm

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive heart disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 hours6-7 years11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, OF injury bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1954, to OCT 5, 1955, that I last saw the deceasedalive on Oct 5, 1955, and that death occurred at 12:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 10/8/55 Parkwood Cn Ba 1 to md

Oct 8-1955 Maids Reframer Local Funeral Home 7401 Belair Rd.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

133 1/2 North Ave

BUREAU V. S.

OCT 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9475

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09467

Reg. Dist.

No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place) 5yr. 3mos. 23days		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Baltimore 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural, give location) 2631 Park Heights Avenue			
3. NAME OF DECEASED: (First) Morris		(Middle)		(Last) Kalichman		4. DATE OF DEATH (Month) (Day) (Year) October 5, 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 11-10-1894		9. AGE last birthday: 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Russia		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME: Jacob Kalichman				14. MOTHER'S MAIDEN NAME: Mary Madas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) Acute Coronary Thrombosis DUE TO Antecedent cause(s) (b) Coronary Arteriosclerosis Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Generalized arteriosclerosis							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Geo. J. M. Kieffer		1010 Leaden		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-5-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 10-7-55		NAME OF CEMETERY OR CREMATORY Mt. Carmel		LOCATION (city, town, or county) Balto (State) MD	
DATE REC'D BY LOCAL REG. 10-7-55		REGISTRAR'S SIGNATURE W. H. Adair		24. FUNERAL DIRECTOR Jack Lewis		ADDRESS 2100 Cutaw Pl	

4-12-11

1000

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

REPORT OF THE
SALT LAKE CITY WATER RESOURCES DIVISION

ON THE
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE
YEAR 1911

BY
J. H. HARRIS

CHIEF OF DIVISION

SALT LAKE CITY, UTAH

1912

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

SALT LAKE CITY, UTAH

REPORT OF THE

SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE

YEAR 1911

BY

J. H. HARRIS

CHIEF OF DIVISION

9478

CERTIFICATE OF DEATH

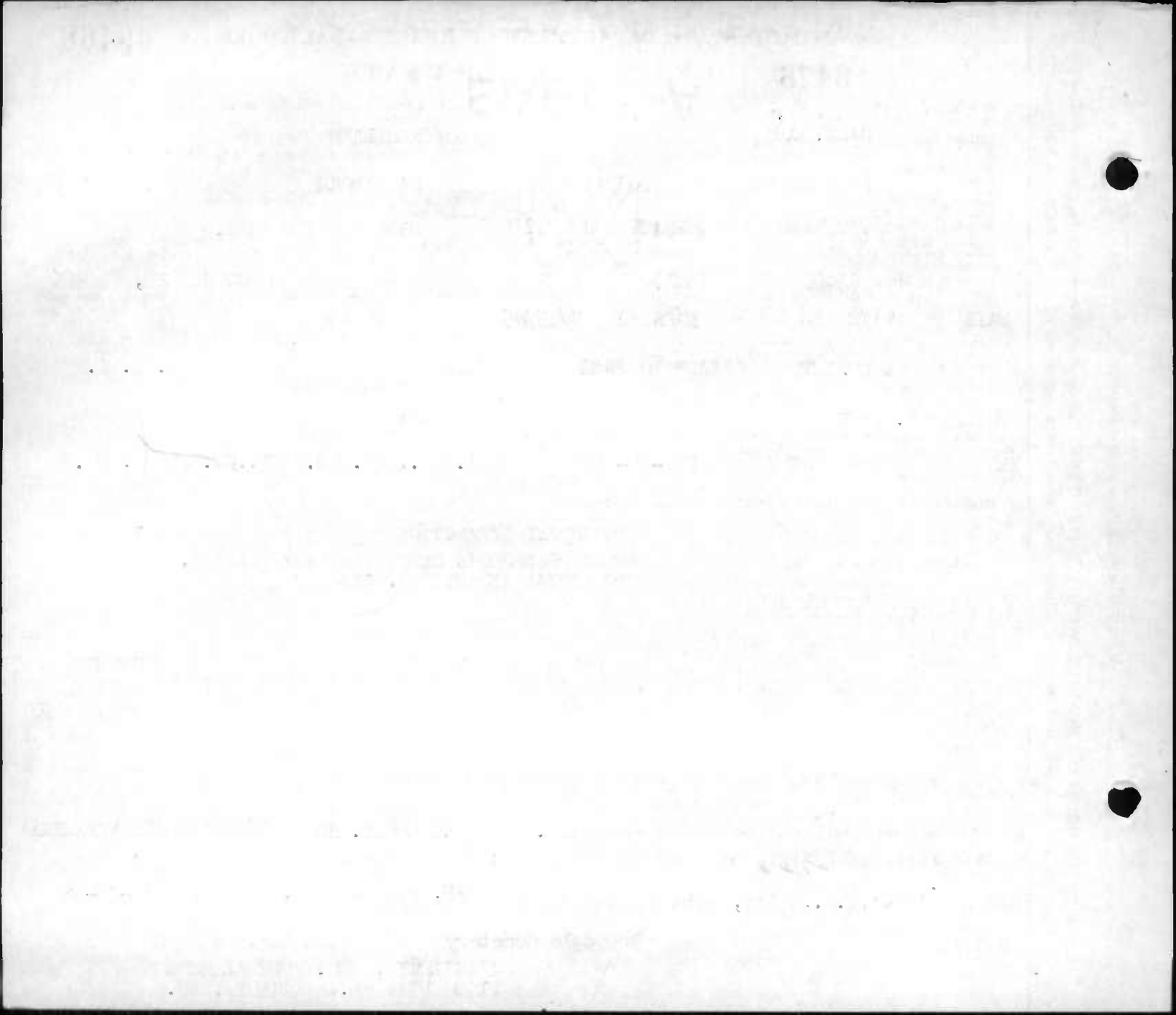
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN FORT HOWARD		80 DAYS		OR TOWN BALTIMORE 3Y01-1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 VETERANS ADMINISTRATION HOSPITAL				4318 PIMLICO ROAD,			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) JACOB		(NMI)		KATZ		OF DEATH: OCTOBER 20, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 60 HRS. Hours
MALE	WHITE	MARRIED	5/15/95	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
MERCHANT		READY TO WEAR		RUSSIA		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
PHILLIP W. KATZ				FANNIE MN: UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
YES (If Yes, give war or dates of service) WW I		215-10-8186		CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 420.1						1 HOUR	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (260X)							
DUE TO (A) MYOCARDIAL INFARCTION							
DUE TO (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, MYOCARDIAL INFARCTION, OLD							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DIABETES MELLITUS						UNKNOWN	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from AUG. 1, 1955 , to OCT. 20, 1955 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
FRANCIS DICKEY, M.D., Chief, Medical Service		VAH, FORT HOWARD, MARYLAND		10-20-55			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
BURIAL		10-21-55		Rosedale Cemetery		ROSEDALE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
21-55		Jack Lewis, Inc.		JACK LEWIS, INC. FUNERAL HOME		2100 EUTAW PL., BALTIMORE, MD.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09469

9477

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Whitemarsh, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Whitemarsh, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ebenezer - Red Lion Rds.</u>		STREET ADDRESS (If rural, give location) <u>Ebenezer - Red Lion Rds.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Viola</u> (Middle) <u>Olie</u> (Last) <u>Keithley</u>	4. DATE OF DEATH	(Month) <u>Oct.</u> (Day) <u>18</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 11, 1882</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cecil County, Maryland</u>
13. FATHER'S NAME <u>John E. George</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Chenoweth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Charles S. Keithley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Infarction</u>	5 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive Cardiovascular Dis.</u>	
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Benign Carcinoma Stomach 3 yrs</u>
---	---------------------------------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

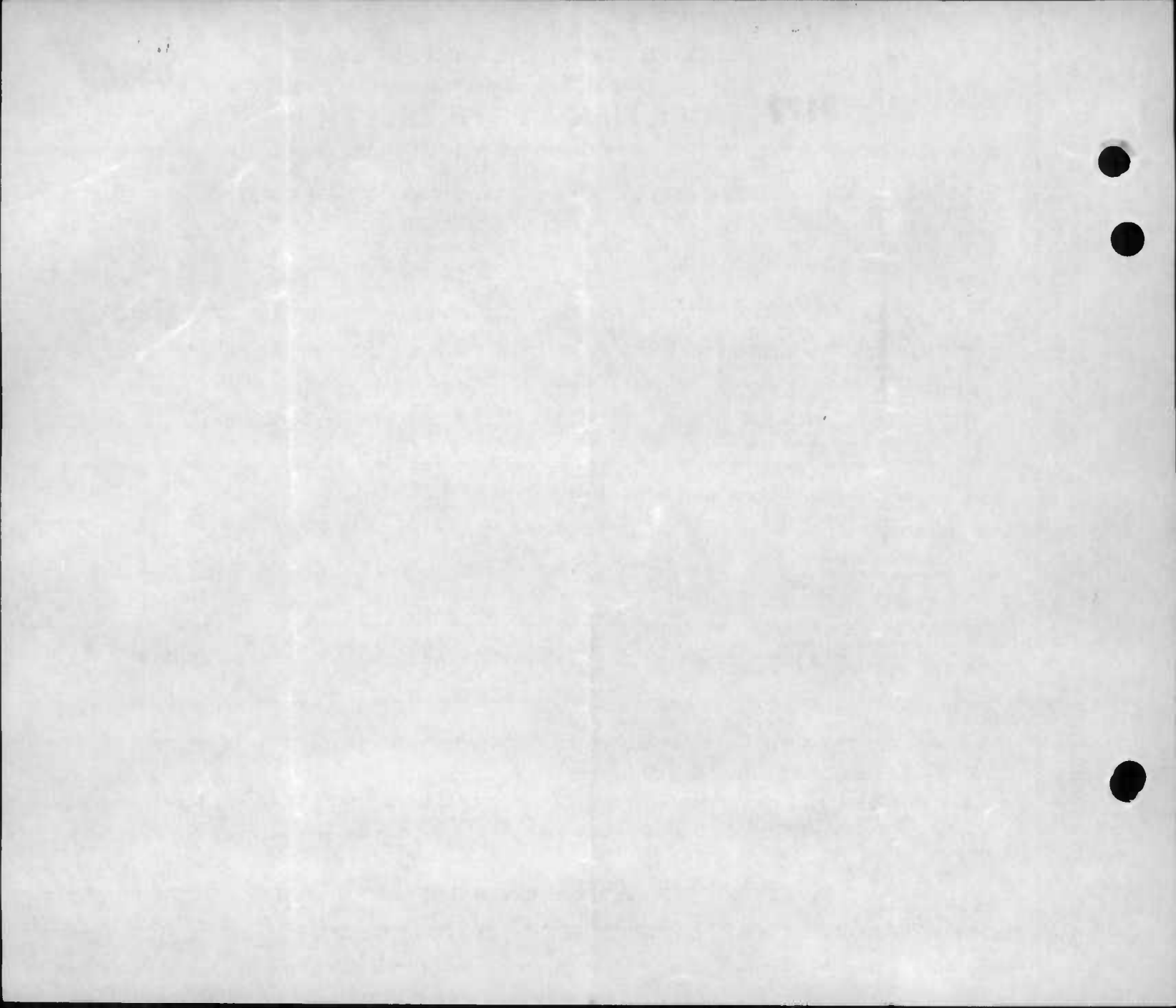
22. I hereby certify that I attended the deceased from 3/3, 1947, to Oct. 18, 1955, that I last saw the deceased alive on 10/17, 1955, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

SIGNATURE <u>Clifford F. Hudson M.D.</u>	(Degree or title)	ADDRESS <u>Fork Md - 10/18/55</u>	DATE SIGNED <u>10/18/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Oct. 23, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Baker's</u>	LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>
DATE REC'D BY LOCAL REG. <u>10/27/55</u>	REGISTRAR'S SIGNATURE <u>H. W. ...</u>	24. FUNERAL DIRECTOR <u>Lassahn Funeral Home - 7401 Belair Rd</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9478

09470

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore	CHESACO PARK
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave. West of North Point Road		STREET ADDRESS 7911 OAKDALE AVE 513 S. Lakewood Avenue	
3. NAME OF DECEASED: (First) William J. (Middle) J. (Last) Kenny, Jr.		4. DATE OF DEATH (Month) October (Day) 14 (Year) 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: JUNE 13-1933
9. AGE last birthday: 22 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min.	
11. BIRTHPLACE (State or foreign country): BALTO MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William J. Kenny Sr		14. MOTHER'S MAIDEN NAME: MARGARET V. FINNICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 713 30-2494	
17. INFORMANT & ADDRESS: PITAMAE KENNY 7911 OAKDALE AVE			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
825X Immediate cause (a) Craniocerebral injury DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street)	21c. (City or town) Baltimore (County) Maryland (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Speeding auto - out of control
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE William J. Kenny Jr		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/14/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 10/14/55
23. BURIAL, CREMATION, REMOVAL (Specify): Removal	DATE THEREOF 10/18/1955 (NAME OF CEMETERY OR CREMATORY) HOLY REDEEMER (LOCATION (City, town, or county) (State) BALTO MD)	
DATE REC'D BY LOCAL REG. 10-12-55	REGISTRAR'S SIGNATURE Dr. J. H. Redmond	24. FUNERAL DIRECTOR Pratt & Stricker Srs ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND

9479

09471

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Reisterstown Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown Mills</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reisterstown Road</u>		STREET ADDRESS (If rural, give location) <u>Reisterstown Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>FRANK</u> <u>KINLO</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 19</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 20, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Millwright</u>	9. AGE last birthday <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Don't know</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Don't know</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Balti. County Welfare Board, Towson</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>450.0</u> <u>Arteriosclerosis, generalized</u>			<u>2 years</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a)..... (b)..... (c).....			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 5, 1955</u> to <u>Oct 19, 1955</u> , that I last saw the deceased alive on <u>Oct 17, 1955</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles S. McWilliams M.D.</u>		ADDRESS <u>Reisterstown</u>	
DATE SIGNED <u>October 19, 1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE <u>Oct 21, 1955</u>		<u>Dev Park</u>	
LOCATION (City, town, or county) (State) <u>Reisterstown</u> <u>md</u>			
DATE REC'D BY LOCAL REG. <u>10-21-55</u>		24. FUNERAL DIRECTOR <u>Wm. Berryman & Sons</u>	
REGISTRAR'S SIGNATURE <u>Mary B. Elise</u>		ADDRESS <u>Reisterstown</u>	

MARGIN RESERVED FOR BINDING

UNITED STATES OF AMERICA

BUREAU V. S.

OCT 25 1955

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

9480

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CATONSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2200 OLD FREDERICK RD.		STREET ADDRESS (If rural, give location) 2200 OLD FREDERICK RD.	
3. NAME OF DECEASED (Type nr Print)	(First) CARL	(Middle) HENRY	(Last) KINZEL
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	4. DATE OF DEATH (Month) OCT. (Day) 3 (Year) 1955
8. DATE OF BIRTH April 15, 1886	9. AGE last birthday 69 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HIGH TENSION OPERATOR-RET. CAR. CO. ELEC. CO.	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHRISTIAN KINZEL		14. MOTHER'S MAIDEN NAME MINNIE BOCKMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) NO		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Carl H. Kinzel - 2200 Old Fred. Rd.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
526X Immediate cause (a).....	BRONCHIECTASIS BRONCHITIS.	2.5 yrs.
Antecedent cause(s) (b).....	HEPATITIS WITH JAUNDICE.....	1 MO
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION 10	19b. MAJOR FINDINGS OF OPERATION 7	
21. ACCIDENT SUICIDE HOMICIDE (Specify) 7	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan-6, 1953** to **Oct-3, 1955**, that I last saw the deceased

alive on **Oct 1 - 1955**, and that death occurred at **6:45 A.M.**, from the causes and on the date stated above.

SIGNATURE **J. Lloyd Johnson** (Degree or title) **not** ADDRESS **Catonville, Md.** DATE SIGNED **10/5/55**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	10-6-55	Woodlawn Cem.	Woodlawn	Md.

DATE REC'D BY LOCAL REG. 10/5/55	REGISTRAR'S SIGNATURE V.E. Harry	24. FUNERAL DIRECTOR Exley Funeral Home, Catonville, Md.	ADDRESS
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MARGIN RESERVED FOR BINDING

BUREAU V. 8

OCT 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09473

9481

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 3401.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ridgewood Manor		STREET ADDRESS (If rural, give location) 3407 Milford Ave.	
3. NAME OF DECEASED (Type or Print) Henry Klauti		4. DATE OF DEATH Oct. 11, 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH 8/19/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Ludwig Cab. Mak.	9. AGE last birthday 80 yrs.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. 212-01-5608-A	
17. INFORMANT Hannah Klauti		3407 Milford Ave. Balto.	

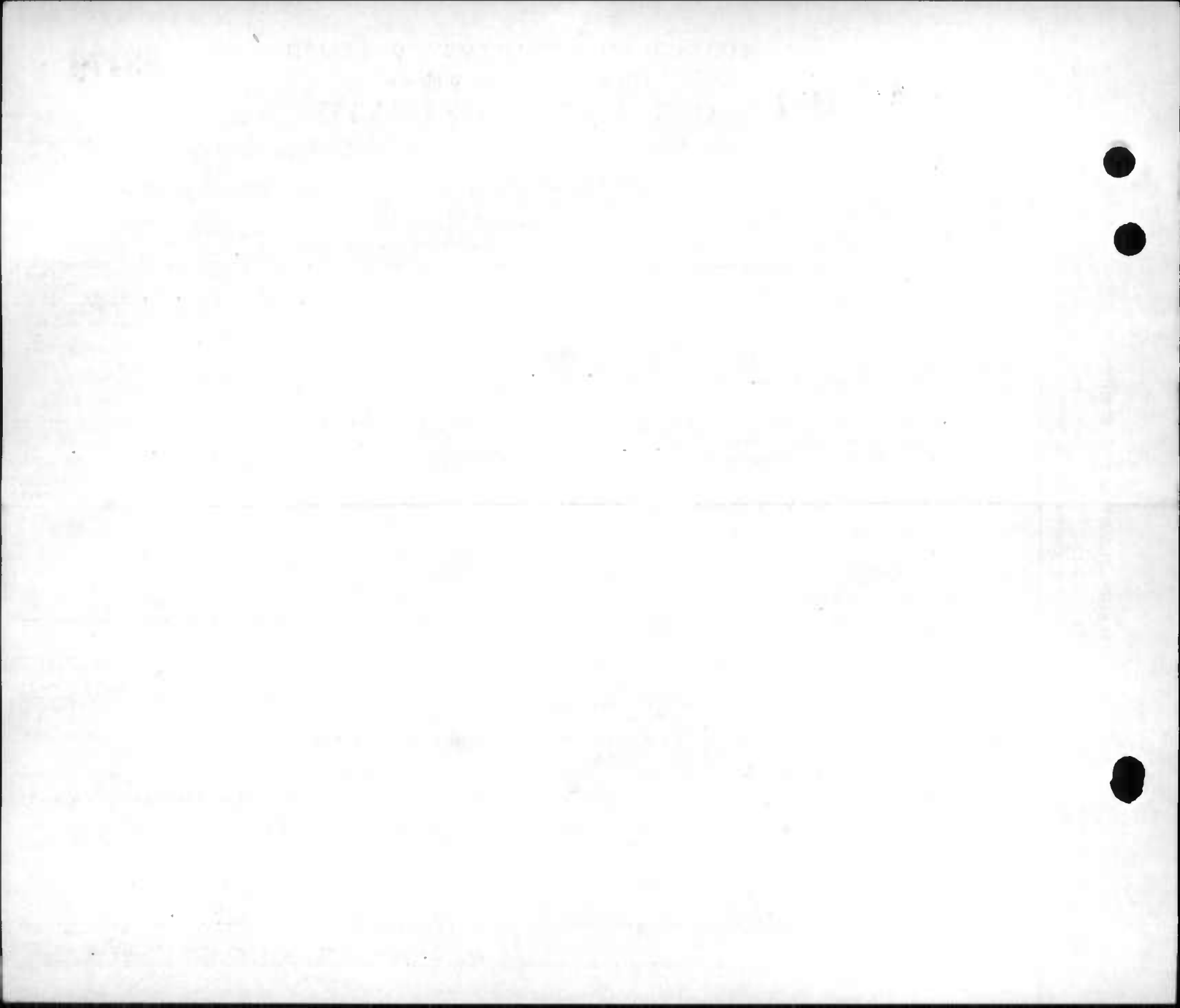
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
450.0 Immediate cause (a) Infection of age		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis (General)		
(c) Phlebitis of leg (left)		3 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-11, 1955**, to **10-11, 1955**, that I last saw the deceased alive on **10-11, 1955**, and that death occurred at **10:15 a.m.**, from the causes and on the date stated above.

SIGNATURE Dr. Thomas Y. Abbott	DATE THEREOF 10/14/55	NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	LOCATION (City, town, or county) (State) Woodlawn Md.
DATE REC'D BY LOCAL REG. 10-13-55	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Harry A. Armacost	ADDRESS 4204 Ridgewood Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9482

CERTIFICATE OF DEATH

Reg. Dist. No.

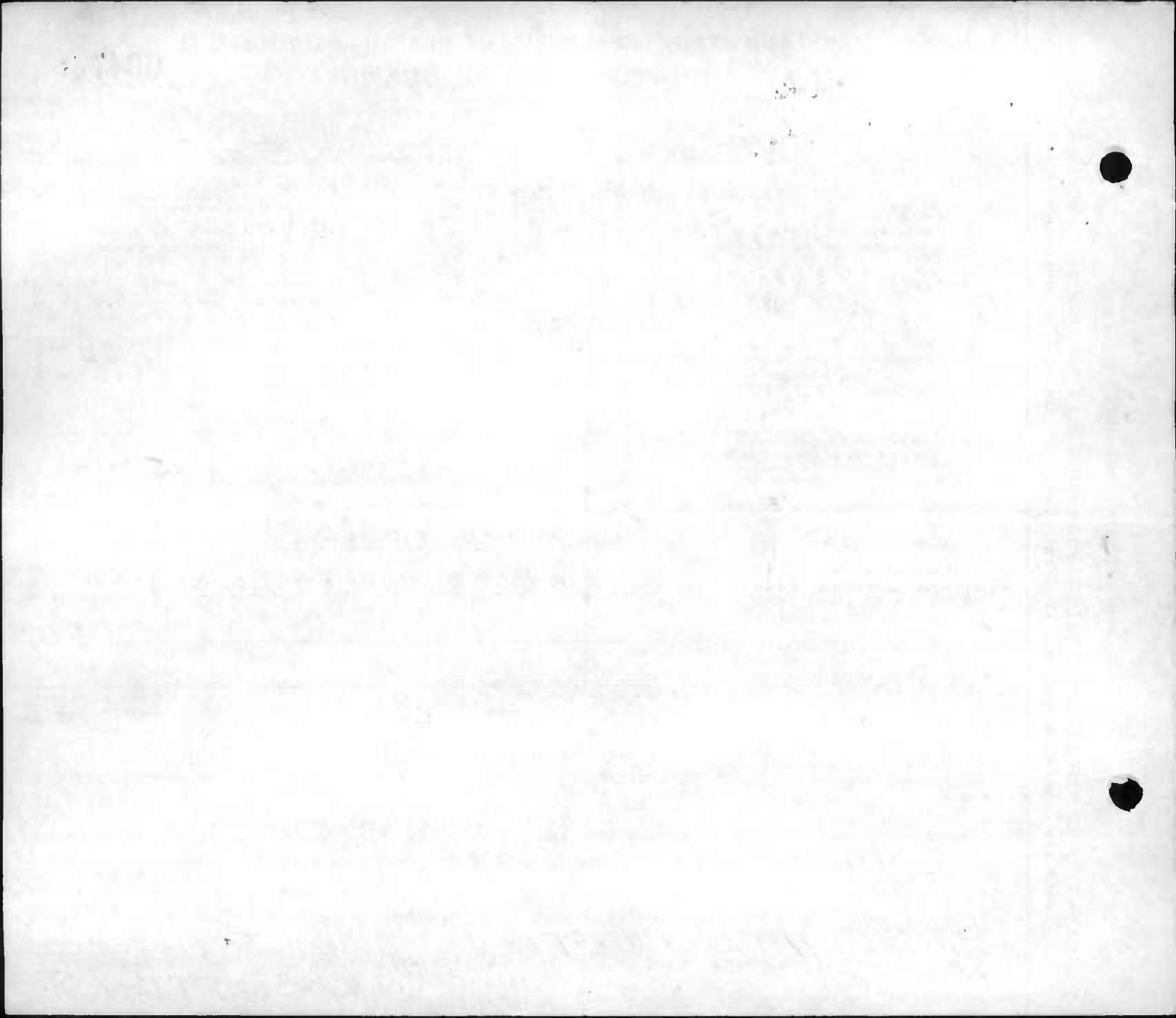
09474

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>6/11/54 - 10/29/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto. City</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Spring Grove St. Hospital</u>		STREET ADDRESS (If rural give location) <u>2235 Hilton Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FREDERICK JUSTICE KOCHLER</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>10 29 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>2/1/1871</u>
9. AGE last birthday <u>84</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>WILLIAM KOCHLER</u>	
14. MOTHER'S MAIDEN NAME: <u>MARY MILLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>LULA KOCHLER - 2235 Hilton St.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>450.0 CARDIAC FAILURE</u>			<u>10/28/55</u>
ANTECEDENT CAUSE (B) <u>ADVANCED ARTERIOSCLEROSIS</u>			<u>to</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			<u>10/29/55</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 4, 1953</u> , to <u>10/29, 1955</u> , that I last saw the deceased alive on <u>10/29, 1955</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Sheela Wachler</u>		M. D. <u>Spring Grove State Hosp.</u> DATE SIGNED <u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-1-55</u>	NAME OF CEMETERY OR CREMATORY <u>Western</u>	LOCATION (City, town, or county) (State) <u>Balto, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>10/31/55</u>	REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Cooper 12175 Paul St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Item 2, Film 188 10-27-55 et

9483

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (if outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 7yr3mos12days		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (if rural give location) 16 Maempel Lane Seton Institute			
3. NAME OF DECEASED: (First) John (Middle) (Last) Lahner				4. DATE (Month) (Day) (Year) OF DEATH: October 12, 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 4, 1872	9. AGE last birthday 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoemaker		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Germany		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME: Jhon B. Lahner				14. MOTHER'S MAIDEN NAME: Margaret Lahner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unknown		16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 446X Uremia						Approx. 2 weeks	
ANTECEDENT CAUSE (B) Arteriosclerotic nephrosclerosis						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized arteriosclerosis						Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7- , 19 53 to 10-12- , 19 55 that I last saw the deceased alive on 10-11- , 19 55 , and that death occurred at 1:20A M , from the causes and on the date stated above.							
SIGNATURE S. Wachler				DATE SIGNED October 10-13-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL				NAME OF CEMETERY OR CREMATORY Spring Grove State Hospital			
DATE REC'D BY LOCAL REGISTRAR Oct. 18, 1955				LOCATION (City, town, or county) (State) Catonsville 28, Maryland			
REGISTRAR'S SIGNATURE T. H. H. H.				24. FUNERAL DIRECTOR ADDRESS 295 GREEN ST MD			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

OCT 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 094777

9484

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 7 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) 842 Wildwood Parkway			
3. NAME OF DECEASED: (First) (Middle) (Last) Harry P. Lambros				4. DATE (Month) (Day) (Year) OF DEATH: October 20, 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 1-10-1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant cook		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Greece		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Peter Lambros				14. MOTHER'S MAIDEN NAME: Diana Kaludis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.1							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Coronary thrombosis						7 days	
DUE TO							
(B) Arteriosclerotic cardiovascular disease						Years	
DUE TO							
(C) Residual hemiplegia							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic arthritis							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-14- , 19 55 , to 10-20- , 19 55 that I last saw the deceased alive on 10-20- , 19 55 , and that death occurred at 11 A. M. from the causes and on the date stated above.							
SIGNATURE S. Wachler		ADDRESS Spring Grove State Hospital		DATE SIGNED 10-20-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/22/55		NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR October 22, 1955		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR Wm. J. Tichenor & Sons - Baetz, 17 Md		ADDRESS	

MAINTENANCE STATE DEPARTMENT OF LAND AND NATURAL RESOURCES
CONSTRUCTION FOR THE PUBLIC
1952

NO.	DATE	DESCRIPTION	AMOUNT
1	1-1-52
2	1-15-52
3	2-1-52
4	2-15-52
5	3-1-52
6	3-15-52
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98	1-15-56
99	2-1-56
100	2-15-56

9485

CERTIFICATE OF DEATH

Reg. Dist. No. 3601.4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 16 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 5302 ETHELBERG AVENUE			
3. NAME OF DECEASED: (First) EDGAR (Middle) (NMI) (Last) LA TART				4. DATE (Month) (Day) (Year) OF DEATH OCTOBER 9 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH: 7/9/89	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY: CATERERS		11. BIRTHPLACE (State or foreign country): CLAYTON, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JOHN LA TART				14. MOTHER'S MAIDEN NAME: LETITIA MC CARTHY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk:) YES (If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 109-05-2165		17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						9 MONTHS	
IMMEDIATE CAUSE (A) ADENOCARCINOMA OF RECTUM WITH METASTASES							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 23 1955 , to OCT. 9, 1955 , that death occurred at 5:00PM , from the causes and on the date stated above. SIGNATURE FRANCIS G. DICKEY, M.D. Chief, Medical Service D. VAH, FORT HOWARD, MARYLAND 10-10-55 ADDRESS DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10/12/55		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-12-55		REGISTRAR'S SIGNATURE DMR		24. FUNERAL DIRECTOR VERNON C. LEMMON FUNERAL HOME		ADDRESS 4611 PARK HEIGHTS AVE., BALTIMORE, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

100

100

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09479

9436

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR Baltimore		3001-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Wayne Nursing Home Smithwood & Summit Aves.				STREET ADDRESS (If rural give location) 4507 Springdale Ave.			
3. NAME OF DECEASED: (First) CARRIE (Middle) W. (Last) LEVY				4. DATE OF DEATH: (Month) Oct (Day) 24 (Year) 1955			
5. SEX: Female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed		8. DATE OF BIRTH: July 18, 1872	
				9. AGE last birthday: 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife		10b. KIND OF BUSINESS OR INDUSTRY: at home		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Samuel Flaunlacher				14. MOTHER'S MAIDEN NAME: Sarah Wornitz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Mrs. Irvin Gordon - 4507 Springdale Ave.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
334X Immediate cause (a) Hebiplegic Right.							
Antecedent causes (s) (b) Generalized Arteriosclerosis							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While at Work		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953, 1955, to 24 Oct. 1955, that I last saw the deceased alive on 22 Oct. 1955, and that death occurred at 1:30 A.M. from the causes and on the date stated above.							
SIGNATURE We m. G. M. D.		(Degree or title)		ADDRESS 1707 Edmund Ave. Catonsville 28md		DATE SIGNED 24 Oct. 55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 10/26/55		NAME OF CEMETERY OR CREMATORY Balto. Hebrew Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR 10/24/55		REGISTRAR'S SIGNATURE G. W. Hedright		FUNERAL DIRECTOR J. L. Lickens & Sons - Balto		ADDRESS 17md	

STANDARD AIR 1000

STANDARD AIR 1000 - 1000 - 1000

CERTIFICATE OF DEATH

Reg. Dist. No.

9487

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN Essex				TOWN Essex			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 361 Townsend Rd.				STREET ADDRESS (If rural, give location) 619 FRANKLYN Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Chancery A. Lewis				10 - 15 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	White	MARRIED	Nov 15, 1884	70 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
MAINTENANCE				GLEN - MARTIN		Pa.	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
John Lewis				U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
				216-07-4556		Estelle Lewis (Same)	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
199.9 Immediate cause (a) Metastatic carcinoma, intra-abdominal and pulmonary		1 yr
Antecedent cause(s) (b) Origin unknown		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

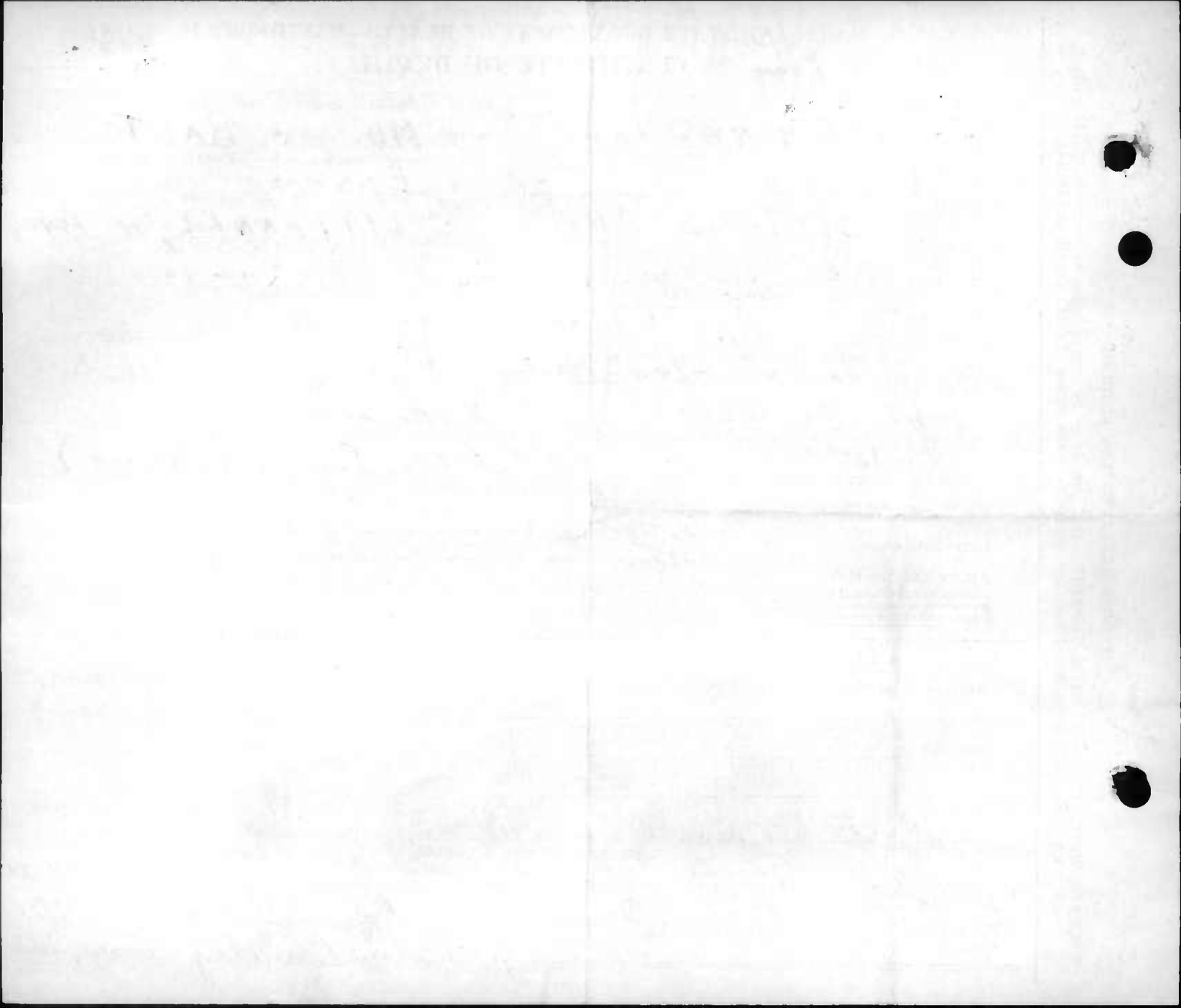
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	HOMICIDE	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not while	HOW DID INJURY OCCUR?
OF INJURY	M. work <input type="checkbox"/> at work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from Oct 10, 1955 , to Oct 15, 1955 , that I last saw the deceased alive on Oct 14, 1955 , and that death occurred at 1:40 A.M. , from the causes and on the date stated above.			
SIGNATURE Joseph Lynch		(DEGREE OR TITLE) ADDRESS 423 Eastern Ave	
DATE SIGNED 10/17/55			
23. BYRIAL, CREMATION REMOVAE (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-18-55	Oak Lawn Cemetery	Balto. MD.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/17/55	W. H. Redick	J. Gordon Connolly	Essex, Md.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

9488

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
<u>50</u> <u>Veterans Administration Hospital</u>		<u>19 days</u>		<u>839 Glade Court</u>		<u>3V01-4</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM C. LEWIS</u>				<u>October 23 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>5/26/98</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>Civil Service</u>		<u>Mount Airy, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas Lewis</u>				<u>Eva O'Neill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WW I</u>		<u>217-12-0937</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
<u>163X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA OF LEFT LUNG</u>						UNKNOWN	
ANTECEDENT CAUSE(S) <u>INFORMED</u> (B) <u>TUBERCULOSIS OF APEX OF LOWER LOBE, LEFT LUNG</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>002X</u> (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 4, 1955</u> to <u>October 23, 1955</u>, the cause of death was <u>CARCINOMA OF LEFT LUNG</u> and the death occurred at <u>4:45 P.M.</u> from the causes end on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>William B. Vandegrift, M.D.</u>				<u>VAH, FORT HOWARD, MARYLAND</u>			
DATE SIGNED				DATE SIGNED			
<u>10-24-55</u>				<u>10-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>OCT 26 1955</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>DATE</u>		<u>Samson L. Foster</u>		<u>Wm. Cook-Blight, Inc. 6009 Harford Rd. Baltimore 14, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

1918, Dec. 28

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

22. SIGNATURE OF CLERK IN CHARGE

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

28. SIGNATURE OF CLERK IN CHARGE

29. SIGNATURE OF CLERK IN CHARGE

30. SIGNATURE OF CLERK IN CHARGE

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

22. SIGNATURE OF CLERK IN CHARGE

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

28. SIGNATURE OF CLERK IN CHARGE

29. SIGNATURE OF CLERK IN CHARGE

INSTRUCTIONS

1. The certificate of death is a legal document and must be filled out by the physician or other qualified person who has attended the deceased. It is the duty of the physician to fill out the certificate of death as soon as possible after the death of the patient. The certificate of death is a legal document and must be filled out by the physician or other qualified person who has attended the deceased. It is the duty of the physician to fill out the certificate of death as soon as possible after the death of the patient. The certificate of death is a legal document and must be filled out by the physician or other qualified person who has attended the deceased. It is the duty of the physician to fill out the certificate of death as soon as possible after the death of the patient.

BUREAU V. 2

OCT 28 1918

RECEIVED

CERTIFICATE OF DEATH

9439

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>9 Days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>formerly of 1102 N. Calvert St.</u>		<u>no permanent address</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES M. LOUGHBOROUGH</u>				<u>October 31 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>9/17/76</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Reporter</u>		<u>News Paper</u>		<u>Little Rock, Arkansas</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James M. Loughborough</u>				<u>Mary W. Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>WW I</u>		<u>Unknown</u>			
				<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>422.1</u> <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO <u>1002.0</u> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
<u>1. Tuberculosis, chronic, Pulmonary, Moderately Advanced, inactive. (2) Decubitus ulcer, lt. foot & ankle</u>						<u>1. Unknown</u>	
<u>3. Chronic Brain Syndrome</u>						<u>2. 4 weeks</u>	
						<u>3. Unknown</u>	
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Oct. 22, 1955</u>, to <u>Oct. 31, 1955</u>, and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Milton Ginsberg</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
<u>Milton Ginsberg, M.D., Acting Chief, Surgical Service, VAH, FORT HOWARD, MARYLAND 11-1-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/4/55</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Rev. 7/1955</u>		<u>Lawson L. Farley</u>		<u>Wm. J. Tickner & Sons, Inc. North Penna. Ave.</u>			
				<u>Baltimore, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. Dist. No. 38

9490

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Brooklandville,		20 yrs.		OR TOWN Brooklandville, X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Valley Road				STREET ADDRESS Valley Road			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) Harry		(Middle) Percy		(Last) Lucas		(Month) (Day) (Year)	
(Type or Print)						Oct. 16, 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	widowed	March 8, 1876	79 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
President-General Utilities &				Baltimore, Md.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Harry Pike Lucas				Annabelle Merryman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: Md.			
				Mr. Edgar M. Lucas Valley Rd. Brooklandville,			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
153X Immediate cause		(a) DUE TO		Carcinomatosis			
Antecedent cause(s)		(b) DUE TO		Carcinoma of the Colon			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS:							
Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from May 4, 1955, to Oct. 15, 1955, that I last saw the deceased alive on Oct. 15, 1955, and that death occurred at 3:30 A.m., from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
Waverly S. Green, Jr.		M.D.		Pikesville 8, Balto. Co., Md.		Oct. 16, 1955	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 18, 1955		Druid Ridge		Pikesville, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
Oct 21 1955		M. O. Gray		John O. Mitchell & Sons 1900 Eutaw Place			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 28 1965

RECEIVED

9491

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Ohio</i>	COUNTY <i>Hardin</i>
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <i>Cockeysville</i>	LENGTH OF STAY (in this place) <i>9 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Ada</i> <i>72x-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 Beaver Dam Rd</i>	STREET ADDRESS (If rural give location) <i>113 So. Johnson St</i>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Ellen</i>	(Middle) <i>Maude</i>	(Last) <i>Luft</i>	(Month) <i>October</i> (Day) <i>12</i> (Year) <i>1955</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>10 June 1889</i>
9. AGE last birthday: <i>66</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country): <i>Allen County Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>John Hull</i>		14. MOTHER'S MAIDEN NAME: <i>Margaret Witham</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i> (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT & ADDRESS: <i>Son - Paul Harrod, Cockeysville, Ind.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
153X IMMEDIATE CAUSE			
(A) DUE TO <i>Carcinomatosis</i>			<i>over 9 months</i>
ANTECEDENT CAUSE (S)			
(B) DUE TO <i>Cancer of Colon</i>			<i>about 2 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan</i> , 19 <i>55</i> , to <i>Oct</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11 Oct.</i> , 19 <i>55</i> , and that death occurred at <i>Ada, Ind.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Walter T. Kees</i>		DATE SIGNED <i>12 Oct. 1955</i>	
M. D. <i>Cockeysville</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>Oct. 12, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Chiles Funeral Home</i>		LOCATION (City, town, or county) (State) <i>Lima, Ohio</i>	
DATE REC'D BY LOCAL REGISTRAR <i>13 October 1955</i>		REGISTRAR'S SIGNATURE <i>Anne Armistead MacRae</i>	
FUNERAL DIRECTOR <i>John Burne</i>		ADDRESS <i>Son, Johnson, Ind.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 17 1953

RECEIVED

9492

CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN (Rural) Woodlawn		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn (Rural)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Dogwood Road				STREET ADDRESS (If rural give location) Dogwood Road		/	
3. NAME OF DECEASED: (First) (Middle) (Last) SARAH MARGARET MacKENZIE				4. DATE (Month) (Day) (Year) OF DEATH: Oct. 23, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: Sept. 27, 1874	
9. AGE last birthday 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: ? Hannon				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Woodlawn - 7, Md. Miss Adelaide MacKenzie Dogwood Rd			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Carcinomatous							
DUE TO							
(B) Carcinoma of Intestine (Large)							
DUE TO							
(C) Cardio-Vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 1955 / 1		19B. MAJOR FINDINGS OF OPERATION: As above				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954 , 19... to 10/23/ , 19 55 that I last saw the deceased alive on 10/22/ , 19 55 , and that death occurred at 10 P. M, from the causes and on the date stated above.							
SIGNATURE Mr. E. Marten		ADDRESS M. D. Randalltown, Md		DATE SIGNED 10/24/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 26, 1955		NAME OF CEMETERY OR CREMATORY Good Sheppard Cemetery		LOCATION (City, town, or county) (State) Ellicott City, Md.	
DATE REC'D BY LOCAL REGISTRAR 10/24/55		REGISTRAR'S SIGNATURE Mr. E. Marten		24. FUNERAL DIRECTOR Easton Sons		ADDRESS Catonsville, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 9 1955

RECEIVED

CERTIFICATE OF DEATH

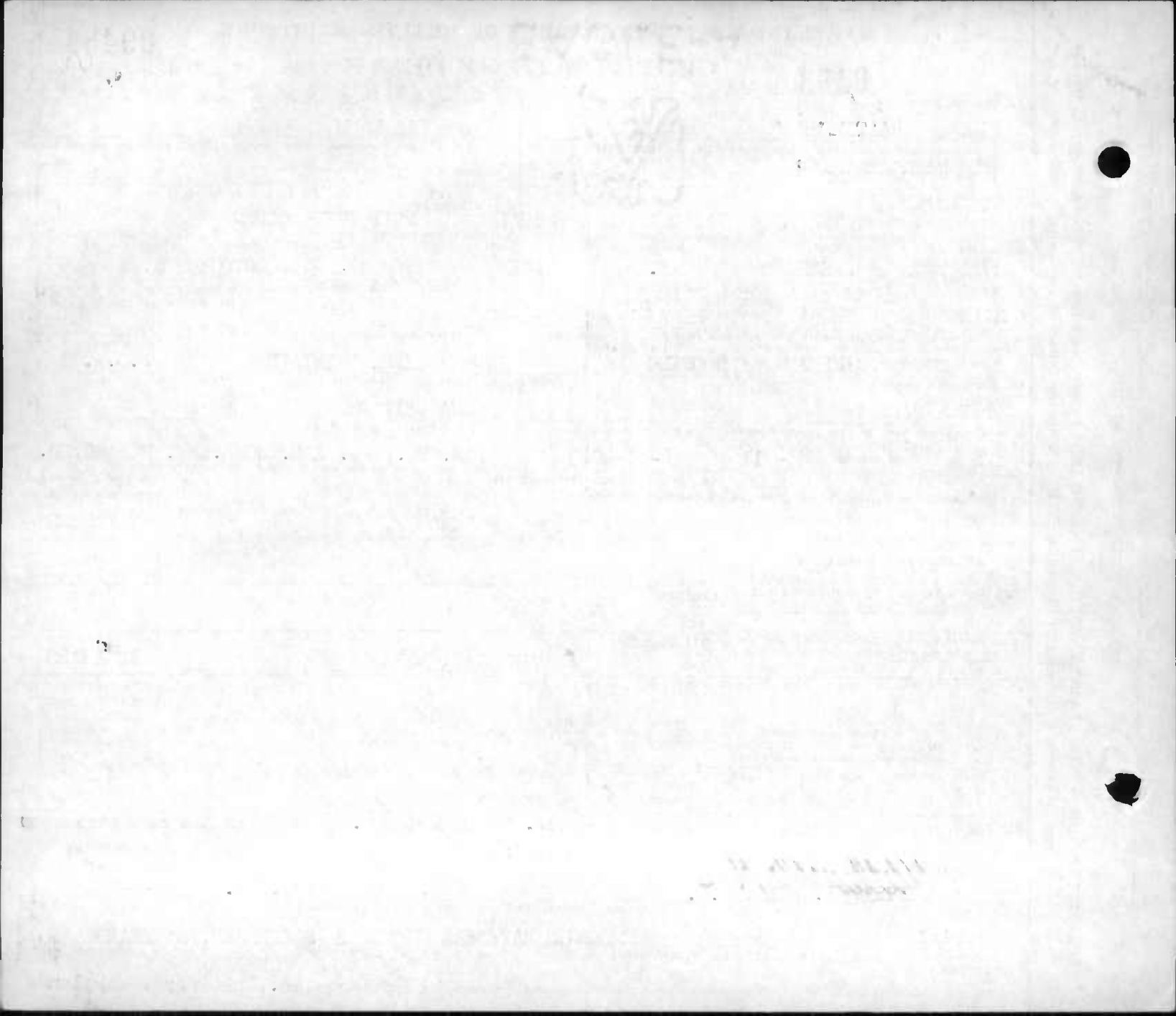
Reg. Dist. No. 3401-4

9493

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN FORT HOWARD		47 days		TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural give location)			
50 VETERANS ADMINISTRATION HOSPITAL				2211 DUKER COURT			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
JOSEPH E. MACKEY				DEATH: OCTOBER 8, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	2-4-97	58 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
SALESMAN		ROOFING		CHURCH HILL, MARYLAND		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
PETER MACKEY				ANNA USILTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
YES WW - 1L		218-07-3343		CLIN.REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CARCINOMA OF LUNG						7 MONTHS	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. RHEUMATIC HEART DISEASE.						12+ YEARS	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 22, 1955 , to Oct. 8, 1955 , and that he died on Oct. 8, 1955 at 2:40 PM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
William E. Hill, M.D.		VAH, Fort Howard, Md.		10-8-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct 11, 1955		BALTIMORE NATIONAL CEMETERY		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
				LILLY & ZEILER FUNERAL HOME			
				1901 Eastern Ave., Baltimore, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

09485

2411 N. Charles Street, Baltimore

9494

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
TOWN <u>2 north</u>		TOWN <u>12-24-2</u>	
HOSPITAL OR INSTITUTION OR House of Pines Nursing Home		STREET ADDRESS (If rural, give location) <u>North Stokes St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u> (First) <u>G</u> (Middle) <u>Mackin</u> (Last)		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE-MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-16-1888</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Mackin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Crane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u></u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause

(a) Myocardial Insufficiency

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension Cardio-Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-15, 1955, to 10-20, 1955, that I last saw the deceasedalive on 10-19, 1955, and that death occurred at 7:00 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>10-22-55</u>	NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>	LOCATION (City, town, or county) <u>Havre de Grace, Md.</u>	(State) <u></u>
--	------------------------------	--	---	-----------------

DATE REC'D BY LOCAL REG. <u>10/21/55</u>	REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	24. FUNERAL DIRECTOR <u>Pennington & Son, 225 S. Washington St</u>	ADDRESS <u>Havre de Grace, Md.</u>
--	---	--	------------------------------------

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 24 1955
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09486

Reg. Dist. No. 40

9495

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Hyde (Rural)</i>		4 yrs		TOWN <i>Hyde (Rural)</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
00 <i>Elder Rd.</i>				<i>Elder Rd.</i>			
3. NAME OF DECEASED (Type or Print) <i>LOIS WADE MACRUM</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>10-26-1955</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>		8. DATE OF BIRTH <i>1-4-1865</i>	
9. AGE last birthday <i>90</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>house</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wm. Wade</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hoopes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <i>Geo. H. Elder, Hyde, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>25 mins</i>			
ANTECEDENT CAUSE(S) DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
SIGNATURE <i>Walter M. Hammitt</i>				ADDRESS (Street, city, town, state) <i>Baltimore, Md.</i>			
DATE <i>10-27-55</i>				DATE SIGNED <i>Oct 26-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		DATE THEREOF <i>10-28-55</i>		NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Wm. Hammitt</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>I. Scott Brooks Sparks</i>		ADDRESS <i>Md.</i>	

CERTIFICATE OF DEATH

0133

00486

Rev. Code, 1955

1. NAME - LAST, FIRST, MIDDLE, INITIAL

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE

6. TIME

7. PLACE

8. CAUSE

9. MANNER

10. SIGNATURE

11. DATE

12. TIME

13. PLACE

14. CAUSE

15. MANNER

16. SIGNATURE

17. DATE

18. TIME

19. PLACE

20. CAUSE

21. MANNER

22. SIGNATURE

23. DATE

24. TIME

25. PLACE

26. CAUSE

27. MANNER

28. SIGNATURE

29. DATE

30. TIME

31. PLACE

32. CAUSE

33. MANNER

34. SIGNATURE

35. DATE

36. TIME

37. PLACE

38. CAUSE

39. MANNER

40. SIGNATURE

41. DATE

42. TIME

43. PLACE

44. CAUSE

45. MANNER

46. SIGNATURE

47. DATE

48. TIME

49. PLACE

50. CAUSE

51. MANNER

52. SIGNATURE

53. DATE

54. TIME

55. PLACE

56. CAUSE

57. MANNER

58. SIGNATURE

59. DATE

60. TIME

61. PLACE

62. CAUSE

63. MANNER

64. SIGNATURE

65. DATE

66. TIME

67. PLACE

68. CAUSE

69. MANNER

70. SIGNATURE

71. DATE

72. TIME

73. PLACE

74. CAUSE

75. MANNER

76. SIGNATURE

77. DATE

78. TIME

79. PLACE

80. CAUSE

81. MANNER

82. SIGNATURE

83. DATE

84. TIME

85. PLACE

86. CAUSE

87. MANNER

88. SIGNATURE

89. DATE

90. TIME

91. PLACE

92. CAUSE

93. MANNER

94. SIGNATURE

95. DATE

96. TIME

97. PLACE

98. CAUSE

99. MANNER

100. SIGNATURE

101. DATE

102. TIME

103. PLACE

104. CAUSE

105. MANNER

106. SIGNATURE

107. DATE

108. TIME

109. PLACE

110. CAUSE

111. MANNER

112. SIGNATURE

113. DATE

114. TIME

115. PLACE

116. CAUSE

117. MANNER

118. SIGNATURE

119. DATE

120. TIME

121. PLACE

122. CAUSE

123. MANNER

124. SIGNATURE

125. DATE

126. TIME

127. PLACE

128. CAUSE

129. MANNER

130. SIGNATURE

131. DATE

132. TIME

133. PLACE

134. CAUSE

135. MANNER

136. SIGNATURE

137. DATE

138. TIME

139. PLACE

140. CAUSE

141. MANNER

142. SIGNATURE

143. DATE

144. TIME

145. PLACE

146. CAUSE

147. MANNER

148. SIGNATURE

149. DATE

150. TIME

151. PLACE

152. CAUSE

153. MANNER

154. SIGNATURE

155. DATE

156. TIME

157. PLACE

158. CAUSE

159. MANNER

160. SIGNATURE

161. DATE

162. TIME

163. PLACE

164. CAUSE

165. MANNER

166. SIGNATURE

167. DATE

168. TIME

169. PLACE

170. CAUSE

171. MANNER

172. SIGNATURE

173. DATE

174. TIME

175. PLACE

176. CAUSE

177. MANNER

178. SIGNATURE

179. DATE

180. TIME

181. PLACE

182. CAUSE

183. MANNER

184. SIGNATURE

185. DATE

186. TIME

187. PLACE

188. CAUSE

189. MANNER

190. SIGNATURE

191. DATE

192. TIME

193. PLACE

194. CAUSE

195. MANNER

196. SIGNATURE

197. DATE

198. TIME

199. PLACE

200. CAUSE

201. MANNER

202. SIGNATURE

203. DATE

204. TIME

205. PLACE

206. CAUSE

207. MANNER

208. SIGNATURE

209. DATE

210. TIME

211. PLACE

212. CAUSE

213. MANNER

214. SIGNATURE

215. DATE

216. TIME

217. PLACE

218. CAUSE

219. MANNER

220. SIGNATURE

221. DATE

222. TIME

223. PLACE

224. CAUSE

225. MANNER

226. SIGNATURE

227. DATE

228. TIME

229. PLACE

230. CAUSE

231. MANNER

232. SIGNATURE

233. DATE

234. TIME

235. PLACE

236. CAUSE

237. MANNER

238. SIGNATURE

239. DATE

240. TIME

241. PLACE

242. CAUSE

243. MANNER

244. SIGNATURE

245. DATE

246. TIME

247. PLACE

248. CAUSE

249. MANNER

250. SIGNATURE

251. DATE

252. TIME

253. PLACE

254. CAUSE

255. MANNER

256. SIGNATURE

257. DATE

258. TIME

259. PLACE

260. CAUSE

261. MANNER

262. SIGNATURE

263. DATE

264. TIME

265. PLACE

266. CAUSE

267. MANNER

268. SIGNATURE

269. DATE

270. TIME

271. PLACE

272. CAUSE

273. MANNER

274. SIGNATURE

275. DATE

276. TIME

277. PLACE

278. CAUSE

9381

CERTIFICATE OF DEATH

09487

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Dundalk LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 275 Baltimore Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk
 STREET ADDRESS (If rural give location) 275 Baltimore Ave.

3. NAME OF DECEASED:

(First) CARLO

(Middle)

(Last) MARCOMIN4. DATE OF DEATH: (Month) (Day) (Year)
October 27 1955

5. SEX:

Male

6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH:

Sept. 23, 1877

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

78 yrs. Months Days Hours Min.10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Dominick Marcomin

14. MOTHER'S MAIDEN NAME:

Dominca ?15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No.

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Albert Marcomin 275 Baltimore Ave-22

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X
Immediate cause(a) Carcinoma of Stomach
DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Sept. 1954 to 10/27, 1955, that I last saw the deceasedalive on 10/26, 1955, and that death occurred at 12 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Oct. 31, 1955

NAME OF CEMETERY OR CREMATORY

St. Stanislaus

LOCATION (City, town, or county)

Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Oct 31-1955 William M Kelly

24. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2112 Dundalk Ave.,

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 2 1955

RECEIVED

9496

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u> 54	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sp. Pt. Hospital</u>		STREET ADDRESS (If rural, give location) <u>24 Hagers Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>masson</u> (Last)		4. DATE OF DEATH <u>10-31</u> (Month) (Day) (Year) 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-13-1896</u>
9. AGE last birthday <u>59</u> yrs. 8 Months 18 Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles L. Masson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bartel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-03-6086</u>	
17. INFORMANT AND ADDRESS <u>Julia S. Masson (wife)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

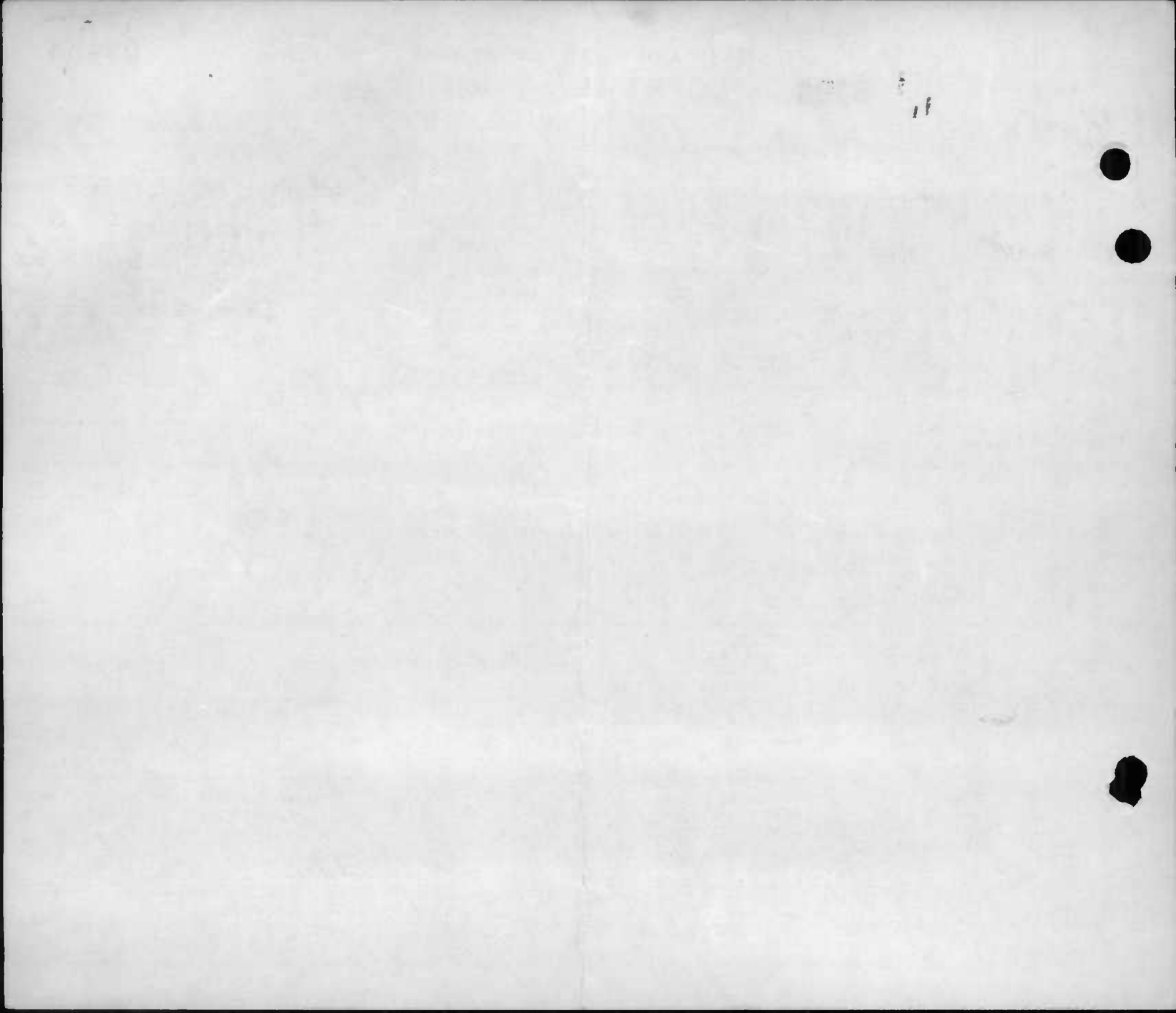
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9382

09489

Reg. Dist. 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN DUN BARCK		LENGTH OF STAY (In this place) 2 1/2 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore SPARROWS POINT (19)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave. West of North Point Road				STREET ADDRESS (If rural, give location) 1223 Forest Road			
3. NAME OF DECEASED: (Type or Print) George		(First) JOHN		(Middle) MATTOLIA		(Last)	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: JAN 6, 1932	
9. AGE last birthday: 23 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): ARMY		11. BIRTHPLACE (State or foreign country): PENNA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: MICHAEL MATTOLIA				14. MOTHER'S MAIDEN NAME: JOSEPHINE (?)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): YES		16. SOCIAL SECURITY No.: 191-22-9386		17. INFORMANT & ADDRESS: JOSEPHINE MATTOLIA - SAME			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
823X Immediate cause (a) Crushed Chest DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street		21c. (City or town) Baltimore		(County) Maryland	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Speeding auto - out of control			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Merri		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 10/14/55					
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 10-17-55		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town or county) (State) Balt. Md.	
DATE REC'D BY LOCAL REG. 10-17-55		REGISTRAR'S SIGNATURE Mrs. Edith H. Hickey		24. FUNERAL DIRECTOR Walter Brudo / Bradley, Hurdock, W.D.		ADDRESS	

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RECEIVED - COMMUNICATIONS SECTION

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BUREAU V. 8

RECEIVED - OCT 18 1955

RECEIVED

9497

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>28 Wingate Road</u>			
3. NAME OF DECEASED: (First) <u>Anna</u> (Middle) <u>G.</u> (Last) <u>McBride</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 26</u> 19 <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Dec. 25, 1903</u>	
9. AGE last birthday <u>51</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>William T. Stinchcomb</u>		14. MOTHER'S MAIDEN NAME: <u>Helen M. Gemp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-8905</u>		17. INFORMANT & ADDRESS: <u>Albert V. McBride, 28 Wingate Rd. Owings Mill</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>410 X</u>							
ANTECEDENT CAUSE (S) <u>Central Embolus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Plumtree Heart Disease: Aortic Stenosis + coronary artery disease, Mitral Stenosis + insuff. Atrial flutter + fibrillation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/21</u> , 19 <u>55</u> , to <u>10-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-25</u> , 19 <u>55</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Sam Aslman</u>		ADDRESS <u>5907 Hargrave Oak Ave</u>		DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/27/1955</u>		REGISTRAR'S SIGNATURE <u>Dorothy A. Newell</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

NOV 7 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09491

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>JONES' CREEK (19)</u>		<u>12 YRS</u>		TOWN <u>JONES' CREEK (19)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2413 KETCHUM AVE.</u>				STREET ADDRESS (If rural give location) <u>2413 KETCHUM AVE</u>			
3. NAME OF DECEASED (Type or Print) <u>ARTHUR WILLIAM MCFARLAND</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10-30-1953</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB 11, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE WIDOW</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. MCFARLAND</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET J. (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>207-03-3855</u>		17. INFORMANT & ADDRESS <u>CATHERINE W. MCFARLAND</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Insufficiency</u>						<u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Oct. 30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>55</u> , and that death occurred at <u>3:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>J. J. Means</u>				ADDRESS (Street, city, town, state) <u>570 D St. Balt. 19 Md</u>		DATE SIGNED <u>11-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>11-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Traylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley</u>		ADDRESS <u>Baltimore, Md</u>	
DATE <u>Nov. 2-55</u>							

1. *Introduction*

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09492

9499

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE 3001.4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE STATE HOSP.				STREET ADDRESS (If rural give location) 1618 N. BENTALOU ST.			
3. NAME OF DECEASED: (First) (Middle) (Last) CORA M. Mc Dermitt				4. DATE (Month) (Day) (Year) OF DEATH: 10 12 1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED	8. DATE OF BIRTH: 3-5-1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: P. SNIVLEY				14. MOTHER'S MAIDEN NAME: MILDRED KOONTA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS: MRS. FRANK MULLIGAN, 2143 W. NORTH DV. BALTO			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 331X							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) CEREBRAL VASCULAR ACCIDENT						10/3/55	
(B) ARTERIOSCLEROSIS						to	
(C)						10/12/55	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 4 , 19 55 , to Oct. 12 , 19 55 , that I last saw the deceased alive on _____, 19____, and that death occurred at 8 A. M. , from the causes and on the date stated above. SIGNATURE Stella Wachler ADDRESS M.D. S. B. St. H. DATE SIGNED 10/12/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/15/55		NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR 10-13-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR [Signature]		ADDRESS [Address]	

9500

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Rocke</u>		LENGTH OF STAY (in this place) <u>3 yrs 6 mos</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Baltimore</u>		TOWN <u>7</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>3700 Cedar Drive - Rocke</u>			
3. NAME OF DECEASED: (Type or Print) <u>Arthur</u> (First) <u>McLean, Sr.</u> (Last)				4. DATE OF DEATH: <u>Oct 9</u> (Month) <u>9</u> (Day) <u>1955</u> (Year)			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>6-22-1870</u>	9. AGE last birthday: <u>85</u> yrs.	10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Photographer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Chicago Tribune</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>				13. FATHER'S NAME: <u>Arthur McLean</u>			
14. MOTHER'S MAIDEN NAME: <u>Ruth E. Hobbs</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>7-1-1-1</u>				17. INFORMANT & ADDRESS: <u>Mr. E. Edward McLean - 3700 Cedar Drive - Balt. Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
490X Immediate cause (a) <u>Congenital Heart Failure</u> DUE TO <u>one day</u>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Globe Pneumonia</u> DUE TO <u>one week</u>							
(c) <u>Generalized Atherosclerosis</u> DUE TO <u>3 years</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10, 1950</u> , to <u>Oct 9, 1955</u> , that I last saw the deceased alive on <u>Oct 8, 1955</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edwin Y. Hight</u> (Degree or title)				ADDRESS <u>8204 Eubank Rd. Balt. 7, Md.</u> DATE SIGNED <u>10/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-12-55</u>		<u>Mt View</u>		<u>Howard Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 11, 1955</u>				REGISTRAR'S SIGNATURE <u>Wm. E. Marten</u>			
24. FUNERAL DIRECTOR <u>Arthur N. Hight - Hyattsville, Md.</u>				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09494

1 9501 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Ca Connville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>1846 W. Pratt Street</u>			
3. NAME OF DECEASED: (First) <u>ELLIZ</u>		(Middle)		(Last) <u>Mc Manus</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10 14 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>December 1878</u>		9. AGE last birthday: <u>76</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Cyril R. Murphy Jr. - 1508 East North Ave</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>422.1</u> <u>Infarctive pneumonia</u>						<u>5 days</u>	
ANTECEDENT CAUSE (B) <u>Pulmonary thrombosis</u>						<u>5 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>53</u> , to <u>10/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/14</u> , 19 <u>55</u> , and that death occurred at <u>10.15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>S. Wachter</u>		M. D. <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>10/14/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Oct 18-1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-17-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. L. [Signature]</u>		ADDRESS <u>1217 St. Paul St</u>	

UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR - BUREAU OF LAND MANAGEMENT

TITLE OF PROJECT (Type in full name of project, including location, and purpose of project.)	
LOCATION (Type in full name of land, including location, and purpose of project.)	
DATE (Type in full date of project, including month, day, and year.)	
TIME (Type in full time of project, including hour, minute, and second.)	
NAME (Type in full name of project, including location, and purpose of project.)	
ADDRESS (Type in full address of project, including street, city, state, and zip code.)	
CITY (Type in full name of city, including location, and purpose of project.)	
STATE (Type in full name of state, including location, and purpose of project.)	
ZIP CODE (Type in full zip code of project, including location, and purpose of project.)	
COUNTY (Type in full name of county, including location, and purpose of project.)	
DISTRICT (Type in full name of district, including location, and purpose of project.)	
SECTION (Type in full name of section, including location, and purpose of project.)	
TOWNSHIP (Type in full name of township, including location, and purpose of project.)	
RANGE (Type in full name of range, including location, and purpose of project.)	
MERIDIAN (Type in full name of meridian, including location, and purpose of project.)	
CORNER (Type in full name of corner, including location, and purpose of project.)	
BEARING (Type in full name of bearing, including location, and purpose of project.)	
DISTANCE (Type in full name of distance, including location, and purpose of project.)	
AREA (Type in full name of area, including location, and purpose of project.)	
VOLUME (Type in full name of volume, including location, and purpose of project.)	
PAGE (Type in full name of page, including location, and purpose of project.)	
TOTAL (Type in full name of total, including location, and purpose of project.)	
REMARKS (Type in full name of remarks, including location, and purpose of project.)	

9592

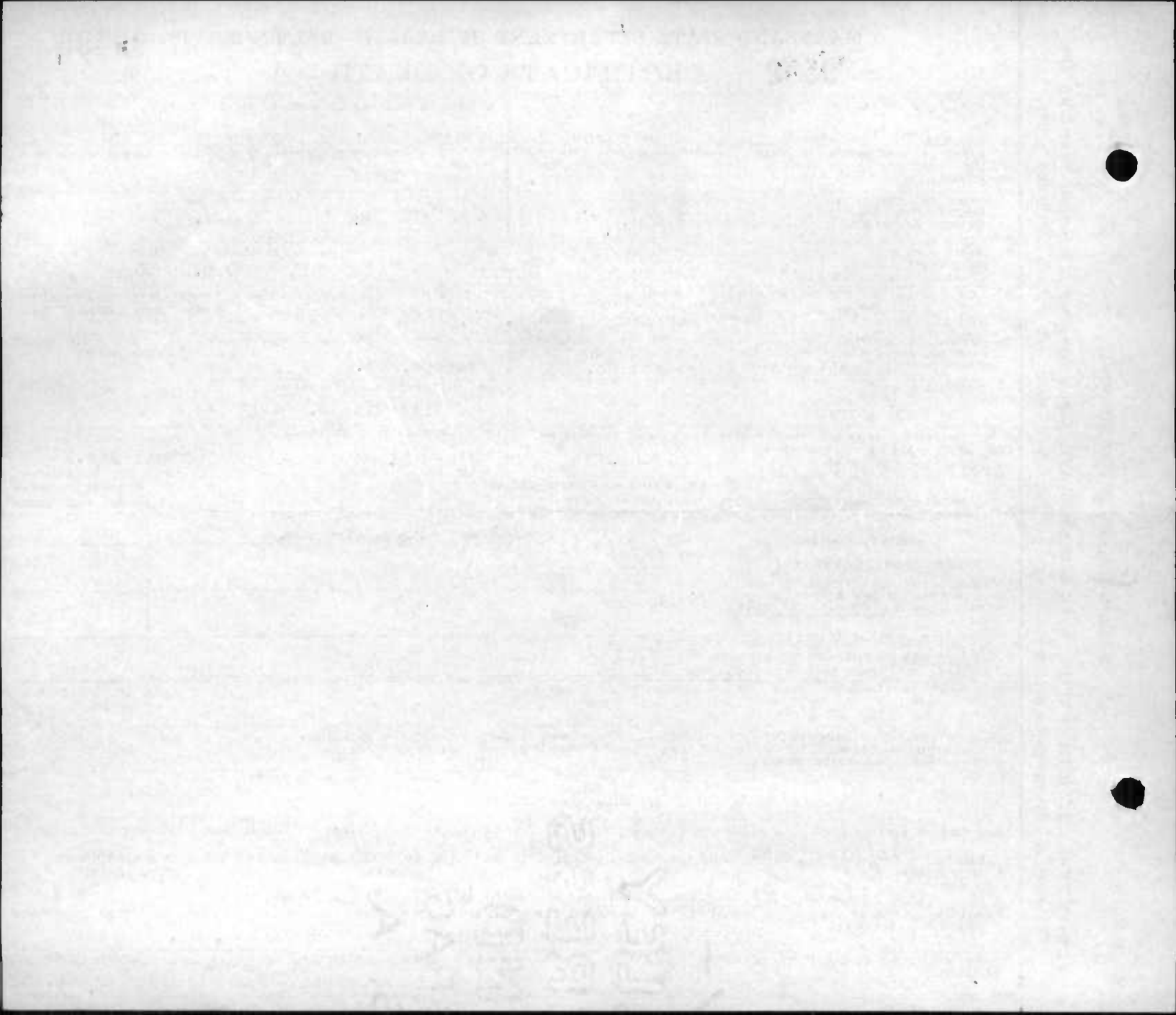
CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Woodlawn</u>	LENGTH OF STAY (in this place) <u>40 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2023 Russell Ave.</u>		STREET ADDRESS (If rural give location) <u>2023 Russell Ave.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Howard</u>	(Middle) <u>Arestess</u>	(Last) <u>Merson</u>	OF DEATH: <u>Oct. 23 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 23, 1896</u>
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 MRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bookkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Produce Co.</u>	
11. BIRTHPLACE (State or foreign country): <u>Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Paul Merson</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth A. Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>213-05-5261</u>	
17. INFORMANT & ADDRESS: <u>Clara M. Merson - 2023 Russell Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/2</u> , 1955, to <u>10/25</u> , 1955, that I last saw the deceased alive on <u>10/10</u> , 1955, and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Milton Schlenoff</u>		DATE SIGNED <u>Md.</u>	
ADDRESS <u>6410 Windsor Mill Rd</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10/27/55</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>10/26/55</u>	REGISTRAR'S SIGNATURE <u>W. H. Haduch</u>	24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hghts. Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9503

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MD.	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HARBOR VIEW	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HARBOR VIEW	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 S. 48th St.		STREET ADDRESS (If rural give location) 500 S. 48th St.	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) ANNA	(Middle) THEODORE	(Last) MILLER	OCT. 1 1955.
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: June 21 1863
9. AGE last birthday 92 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY: HOUSE WORK	11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: ? MILLER	
14. MOTHER'S MAIDEN NAME: UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) -- If Yes, give war or dates of service --	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Henry C. Koos 500 S. 48th St.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
154X IMMEDIATE CAUSE (A) Malignancy of Rectum		(adenocarcinoma) 6 months	
ANTECEDENT CAUSE (S) (B) Elephantiasis		15 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertrophic Arthritis		30 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July , 19 35 , to Oct 1 , 19 55 , that I last saw the deceased alive on Oct 1 , 19 55 , and that death occurred at 12:45 AM , from the causes and on the date stated above.			
SIGNATURE Marie A. Jauer M.D.		DATE SIGNED 10/2/55	
M.D. 1010 NORTH Point Rd. Balt.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10-4-55	
NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		LOCATION (City, town, or county) ANNAPOLIS RD., MD.	
DATE REC'D BY LOCAL REGISTRAR 3-53		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Charles S. Juler		ADDRESS 901 S. CONKLING ST. BALTO., MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

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21. [Illegible]

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97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09497

9594

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>20 Days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>328 W. Camden Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOSEPH F. MILLER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 24, 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/10/87</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-03-2430</u>		17. INFORMANT & ADDRESS <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>HEMORRHAGE, CEREBRAL</u>						<u>3 WEEKS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PULMONARY EMPHYSEMA</u>						<u>UNKNOWN</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 4, 19 55</u> , to <u>October 24, 19 55</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
DATE THEREOF <u>10-28-55</u>				DATE SIGNED <u>10-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. D. L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Dabrowski</u>		ADDRESS <u>2818 E. Baltimore, St. Baltimore, Md.</u>	

10494

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

See Ord. No.

1. UNDER SIGNATURE OF DECEASED

MARRIED

SINGLE

30 days

100 days

The time of death is hereby certified as follows:

Date of death: 10-10-1955

Time of death: 10:00 AM

Place of death: Baltimore, Maryland

Cause of death: Heart disease

Manner of death: Natural

Signature of physician: [Signature]

Signature of medical examiner: [Signature]

Signature of coroner: [Signature]

Signature of registrar: [Signature]

Signature of funeral director: [Signature]

Signature of next of kin: [Signature]

Signature of witnesses: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

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Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

Signature of registrar: [Signature]

NOTIFICATION

BUREAU V. B

Oct 27 1955

RECEIVED

1266
MARYLAND

9505

CERTIFICATE OF DEATH

09498
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>52</u> TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> <u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1501 SUMMIT AVE</u>		STREET ADDRESS (If rural, give location) <u>1501 SUMMIT AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>LOUISE</u>	(Last) <u>MILLER</u>
4. DATE OF DEATH	(Month) <u>10</u>	(Day) <u>15</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 3, 1923</u>
9. AGE last birthday <u>32</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RICHARD OETERS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE O'NEKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>_____</u>	
17. INFORMANT AND ADDRESS <u>Harry L. Miller Jr. 1501 Summit Ave.</u>			

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Myocardial failure</u>		<u>5 days</u>
(b) Antecedent cause(s) <u>ASCVD</u>		<u>Unknown</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3, 1957, to 10-15, 1955, that I last saw the deceased alive on 10-15, 1955, and that death occurred at 945 P m., from the causes and on the date stated above.

SIGNATURE Stephen Lee Hoagness M.D. ADDRESS Catonsville Md DATE SIGNED 10-17-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>10-18-55</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>10/17/55</u>	REGISTRAR'S SIGNATURE <u>V.E. Barry</u>	24. FUNERAL DIRECTOR <u>Grady Funeral Home - Catonsville, Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

RECEIVED

OCT 19 1955

BUREAU V. 3

9506

CERTIFICATE OF DEATH

Reg. Dist. No. 58

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>
OR TOWN <u>TOWSON</u>	LENGTH OF STAY (in this place) <u>3 Mos.</u>	OR TOWN <u>TOWSON</u>	OR TOWN <u>TOWSON</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 HILLSIDE AVE</u>		STREET ADDRESS (If rural give location) <u>11 HILLSIDE AVE</u>	
3. NAME OF DECEASED: (First) <u>MATTIE</u> (Middle) <u>P.</u> (Last) <u>MILLER</u>		4. DATE OF DEATH: (Month) <u>OCT.</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>SEPT. 29, 1869</u>
9. AGE last birthday: <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, (If retired): <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>LEWISTOWN MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>JACOB P. WELLER</u>		14. MOTHER'S MAIDEN NAME: <u>JOANNA WEBB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>MR. G. P. TOFFORD</u>	
17. INFORMANT & ADDRESS: <u>11 HILLSIDE AVE</u>		TOWSON-4-MD.	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>157X</u>		
Immediate cause (a) <u>Carcinoma Paveus</u>		
Antecedent causes (s) (b) <u>DUE TO</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
<u>HOMICIDE</u>	<u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?

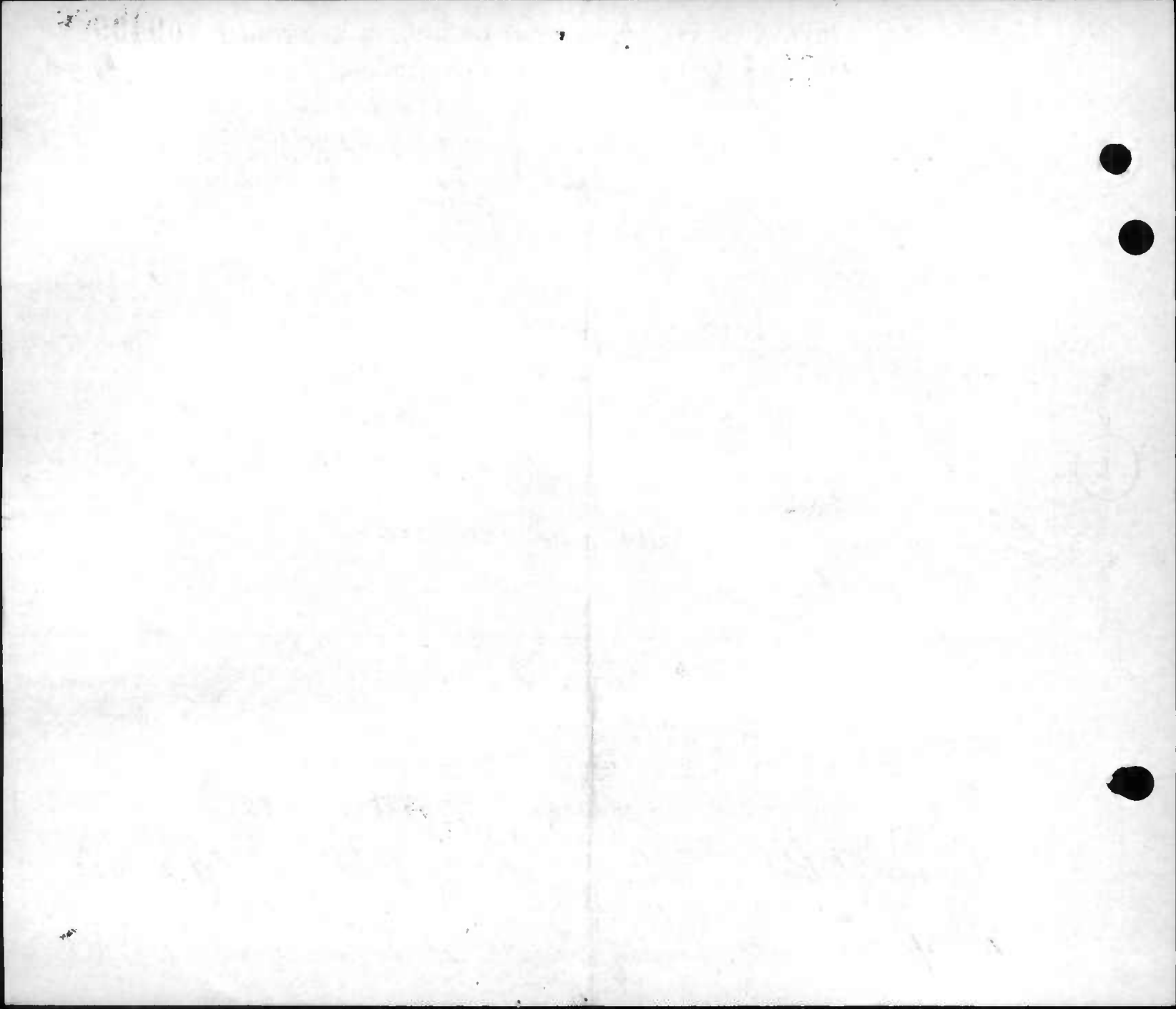
22. I hereby certify that I attended the deceased from Aug. 20, 1955, to Oct 1, 1955, that I last saw the deceased alive on Oct 1, 1955, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

SIGNATURE Laurence C. Post (Degree or title) M.D. ADDRESS 6805 York Rd. DATE SIGNED Oct. 2, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>OCT. 4, 1955</u>	<u>UTICA CHURCH CEM.</u>	<u>FREDERICK Co. MD.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>10-4-55</u>	<u>John Redwood</u>	<u>Henry H. Jenkins & Sons Co.</u>	<u>4905 York Rd.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9517

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09500

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place) 5 mos. 18 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) 514 Cathedral Street			
3. NAME OF DECEASED: (First) (Middle) (Last) Anna V. Mitchell				4. DATE (Month) (Day) (Year) OF DEATH: October 14, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 3-21-1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Taylor				14. MOTHER'S MAIDEN NAME: Isadore Marmsduke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Generalized carcinomatosis						3 months	
ANTECEDENT CAUSE (B) Adenocarcinoma descending colon						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-26- , 19 55 to 10-14- , 19 55 , that I last saw the deceased alive on 10-14- , 19 55 , and that death occurred at 4:35P M, from the causes and on the date stated above. SIGNATURE S. W. Wachter Spring Grove State Hospital DATE SIGNED 10-14-55 M. D. Catonsville 28, Maryland							
23. BURIAL CREMATION REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		10/18-55		Balts. National Cem.		Balts. Ind.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10/17/55		V. E. Harry		Tracy Funeral Home - Catonsville, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 19 1955

RECEIVED

9383

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY 3122 Dunglew Road MARYLAND				3122 Dunglew Rd. Dundalk			
CITY (If outside corporate limits, write TOWN and give nearest town) 53 Dundalk				STATE Md. COUNTY Balto. 53			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location) 3122 Dunglew Road 22			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Page H. Mitchell				Oct. 16, 1955 19			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Jan. 1st. 1887	
				9. AGE last birthday: 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: retired (Grocery)				10b. KIND OF BUSINESS OR INDUSTRY: retired		11. BIRTHPLACE (State or foreign country): Va.	
13. FATHER'S NAME: John Mitchell				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Mrs. Catherine Mitchell, 3122 Dunglew Rd. 22			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.0 Immediate cause (a) Coronary Thrombosis						6 month	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic heart disease						5 yrs	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Cepid, 19 55, to 16 Oct., 19 55 that I last saw the deceased alive on 16 Oct., 19 55, and that death occurred at 10 45 AM, from the causes and on the date stated above.							
SIGNATURE (Degree or title) Ben Saward M.D.				ADDRESS DATE SIGNED 2900 Sunnyside 10-17-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 19/55		Oak Lawn Cem.		Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		SENIOR DIRECTOR		ADDRESS	
10-17-55		[Signature]		Philip Henry Jones		2024 Orleans St. 31	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809502

9598 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<input checked="" type="checkbox"/> TOWN <u>Villa Nova</u>				<u>Pikesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Robb Nursing Home</u> <u>4105 Essez Rd.</u>		STREET ADDRESS (If rural give location) <u>305 Reisterstown Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>MARVIN HERBERT MOORE</u>				<u>Oct. 28, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>divorced</u>	<u>April 27, 1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>Oil Co.</u>		<u>Md.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George R. Moore</u>				<u>Effie E. Gosnell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>				<u>Pikesville, Md.</u> <u>Mrs. Mildred Krumm - 305 Reisterstown Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
148X IMMEDIATE CAUSE (A) <u>Hemorrhage from carotid artery incision</u>							
ANTECEDENT CAUSE (B) <u>Cancer of the Pharynx 2 years</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/26, 1955</u> , to <u>Oct 27, 1955</u> , that I last saw the deceased alive on <u>10/26, 1955</u> , and that death occurred at <u>8 30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Haris Sahman</u>		M. D. <u>1413 Reisterstown Rd Pikesville</u>		DATE SIGNED <u>10/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/31/55</u>		<u>Balto. Cem.</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/31/55</u>		<u>Chas. Hedberg</u>		<u>Mr. J. Pickens & Sons</u>		<u>Balto 17th</u>	

CERTIFICATE OF DEATH

1938

FILE NO. 100-100

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

TOE NAILS

FINGER NAILS

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9599

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Essex
 TOWN Essex
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 307 MARGARET

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY BALTIMORE
 CITY (If outside corporate limits, write RURAL and give nearest town) Essex
 TOWN Essex
 STREET ADDRESS (If rural, give location) 307 MARGARET Ave.

3. NAME OF DECEASED:

(First) GRACE (Middle) (Last) MOSES

4. DATE OF DEATH:

(Month) 10 (Day) 13 (Year) 1955

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED.

Single

8. DATE OF BIRTH:

1881

9. AGE last birthday:

74 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Boston

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Julius Board

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(a)

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden10 yrs

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
 INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1953, to Oct 13, 1955, that I last saw the deceased alive on Oct 13, 1955, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 10/18/55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED

OCT 20 1955

BUREAU V. S.

09504

MARYLAND

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7803 Wilson Avenue</u>		STREET ADDRESS (If rural, give location) <u>7803 Wilson Avenue #14</u>	
3. NAME OF DECEASED (Type or Print) <u>Mr. Thomas H. Nail</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 16 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 6, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Springridge, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. John Nail</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>215-03-8340</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Helen Nail, 7803 Wilson Ave #14</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 Immediate cause (a) <u>acute coronary Occlusion</u>			<u>1 day</u>
Antecedent cause(s) (b) <u>arteriosclerotic Heart Disease</u>			<u>1 yr.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 5, 1950</u> , to <u>Oct 16, 1955</u> , that I last saw the deceased alive on <u>Oct 16, 1955</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>George Sawyer, M.D.</u>		ADDRESS <u>4808 Harford Rd.</u> DATE SIGNED <u>10/17/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
DATE REC'D BY LOCAL REG. <u>10/18/55</u>		REGISTRAR'S SIGNATURE <u>Chas. H. H. H.</u> 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, 5305 Harford Road #14</u> ADDRESS	

MARGIN RESERVED FOR BINDING

Dr. Sawyer

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09505

9511

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH BALTIMORE				2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND BALTIMORE			
COUNTY MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		STATE MARYLAND		COUNTY BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1600 SHORE RD.		LENGTH OF STAY (in this place) 6 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		STREET ADDRESS (If rural give location) 1600 SHORE RD.	
3. NAME OF DECEASED (Type or Print) ANTHONY JOSEPH NARESKY				4. DATE OF DEATH OCT. 28 19 55			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH JUNE 12, 1899	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRCRAFT MECH.		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT MFG.		9. AGE last birthday 56 yrs.		11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND	
13. FATHER'S NAME ANTHONY NARESKY				14. MOTHER'S MAIDEN NAME ZELMA NARESKY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 218-09-9881		17. INFORMANT & ADDRESS ZELMA NARESKY			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
162X IMMEDIATE CAUSE (A) BRONCHIOGENIC CARCINOMA						INTERVAL BETWEEN ONSET AND DEATH 10 months	
ANTECEDENT CAUSE(S) DUE TO (B) vt. lung							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 4, 19 55 , to OCT 28, 19 55 , that I last saw the deceased alive on 10/20, 19 55 , and that death occurred at 7:4 M., from the causes and on the date stated above.							
SIGNATURE A. L. Kolodny		DATE THEREOF OCT. 31, 1955		NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS		LOCATION (City, town, or county) (State) BALTO. CO. MD.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		24. REC'D BY REGISTRAR DATE 10/28/55		25. FUNERAL DIRECTOR'S SIGNATURE James Bugdzinski		ADDRESS 1467 Eastern Ave	

31 OCT 1955

MARYLAND STATE DEPARTMENT OF HEALTH

9512

2411 N. Charles Street, Baltimore

09506

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Baltimore</u>	
53 CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> 55	
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>617 Debaugh Ave</u>		STREET ADDRESS (If rural, give location) <u>617 Debaugh Ave</u>	
3. NAME OF DECEASED (First) <u>Jessie</u> (Middle) <u>Naylor</u> (Last) <u>Naylor</u>		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>11</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb 3 - 1878</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christopher Corcoran</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Fowble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs Marie Horton 617 Debaugh Ave</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) <u>Arteriosclerotic Heart Disease</u>	<u>3 years</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized Arteriosclerosis</u>	<u>?</u>
	(c) <u>Hypertrophied Heart</u>	<u>3 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chr. Bronchitis & Asthma</u>		<u>20 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 6-7-, 1954, to 10-10-, 1955, that I last saw the deceased alive on 10-11-, 1955, and that death occurred at 12 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE OF REMOVAL <u>10/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Cen Long Green Balto Md</u>	LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>10-12-55</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>Larsen Funeral Home</u>	ADDRESS <u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Silver
3105 N. Charles St.

9384

09507

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Brimdale</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Ches. Md</u>	TOWN <u>Ches. Md</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70 Wise Ave</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print) <u>William Frederick Neumann</u>	(First) (Middle) (Last)	(Month) (Day) (Year)	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>9/23/1894</u>
9. AGE last birthday: <u>61</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>FARMER</u>	11. BIRTHPLACE (State or foreign country): <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>GUSTAV NEUMANN</u>		14. MOTHER'S MAIDEN NAME: <u>EMMA PLITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>CHARLES NEUMANN, 70 WISE AVE.</u>	
16. SOCIAL SECURITY No.:			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a)..... DUE TO		<u>Coronary Occlusion</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (b)..... stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>M. G. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/14/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF <u>10/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>SCHWARTZ'S CEMT.</u>	LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>10/14/55</u>	REGISTRAR'S SIGNATURE <u>...</u>	24. FUNERAL DIRECTOR <u>P.F. Hoffmann</u> ADDRESS <u>3218 HUDSON ST.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9513

CERTIFICATE OF DEATH

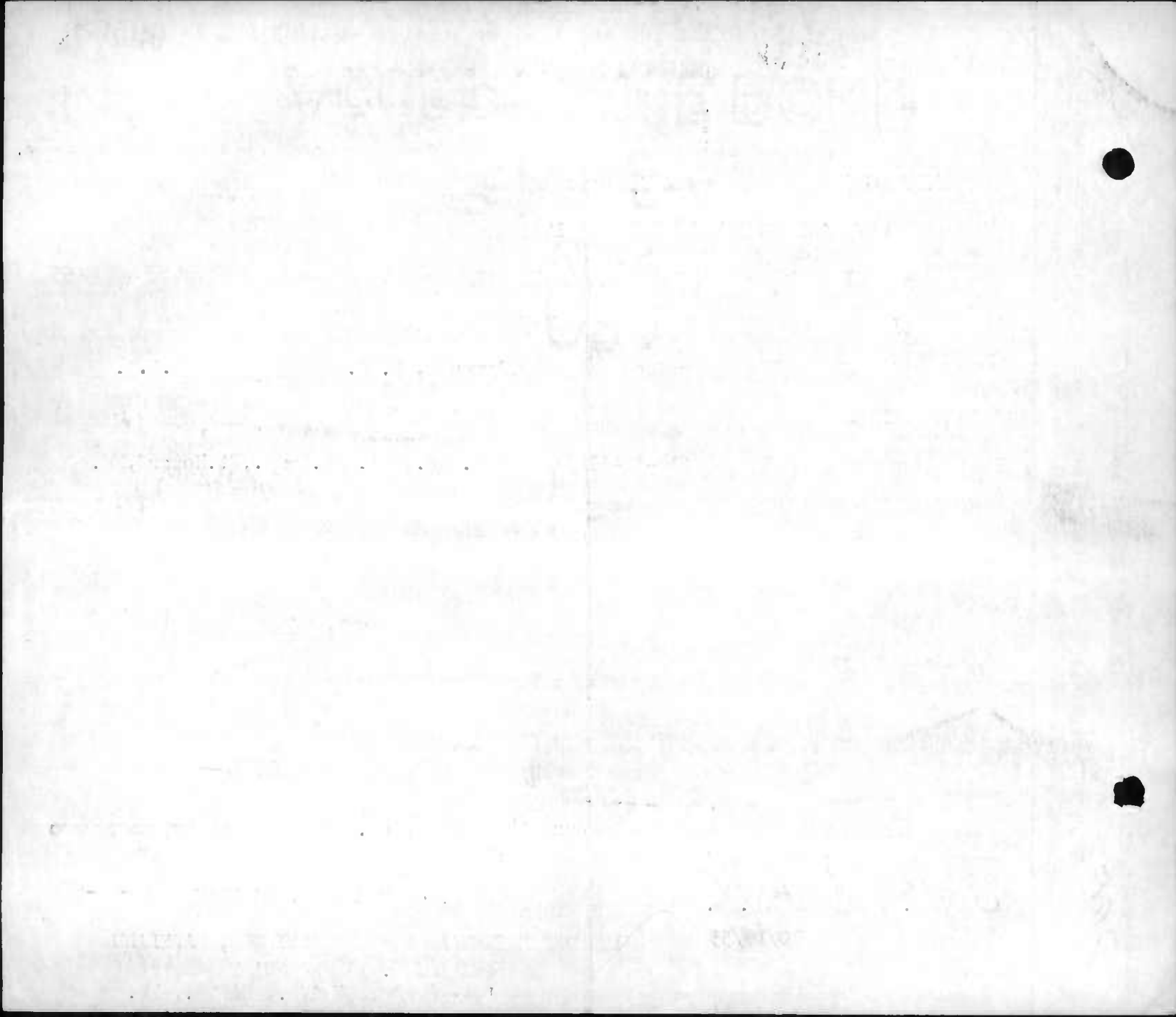
Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>123</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> <u>3101.4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>414 LAURENS STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>RICHARD</u> (NMI) <u>NICHOLS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>OCTOBER 15,</u> 19 <u>55</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>6/11/90</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Drydock</u>		11. BIRTHPLACE (State or foreign country): <u>Plymouth, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ABRAHAM NICHOLS</u>				14. MOTHER'S MAIDEN NAME: <u>SARA BOLDEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> <u>✓</u> (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY No. <u>218-10-1128</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						28 MONTHS	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF BLADDER</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 14, 1955, to Oct. 15, 1955, that I last saw the deceased alive on <u>October 19, 1955</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above. SIGNATURE <u>William B. Vandegriest, M.D.</u> ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>10-16-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10/19/55</u>		<u>BALTIMORE NATIONAL</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-17-55</u>		<u>Wm. B. Vandegriest</u>		<u>CHARLES R. LAW MORTUARY</u>		<u>802 CH MADISON AVE., BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9514

CERTIFICATE OF DEATH

Reg. Dist. No. 09502/4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	DISTRICT OF COLUMBIA	
CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN FORT HOWARD	LENGTH OF STAY (in this place) 48 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 1544 - 25th Street, S. E. ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) JOHN E. NOBLE		4. DATE (Month) (Day) (Year) OF DEATH OCTOBER 19 19 55	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 3-4-96
9. AGE last birthday 59 yrs.		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PATHOLOGIST		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): BRANCHVILLE, S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: GEORGE M. NOBLE		14. MOTHER'S MAIDEN NAME: ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) YES ✓ WW I		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT & ADDRESS: CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 356.1		(A) AMYOTROPHIC LATERAL SCLEROSIS	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 1, 19 55 , to OCTOBER 19 19 55 , that I last saw the deceased live on and that death occurred at 8:30 P.M. from the causes and on the date stated above. SIGNATURE F. Dickey ADDRESS DATE SIGNED			
FRANCIS G. DICKEY, M.D., Chief, Medical Service, VAH, FORT HOWARD, MARYLAND 10-20-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		DATE THEREOF 10-22-55	
NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		LOCATION (City, town, or county) (State) Prince Georges County, Md.	
DATE REC'D BY LOCAL REGISTRAR Oct. 20-55		REGISTRAR'S SIGNATURE Dawson L. Parker	
24. FUNERAL DIRECTOR CHAMBERS FUNERAL HOME		ADDRESS 17 11th Street, S.E. WASHINGTON D. C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

OCT 24 1955

RECEIVED

9515

09510

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. **33**

Reg. Dist.

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN **Reisterstown** LENGTH OF STAY (in this place) **10 yrs**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **Old Hanover Road**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.** COUNTY **Baltimore**
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR TOWN **Reisterstown**
 STREET ADDRESS (If rural, give location) **Old Hanover Road**

3. NAME OF DECEASED:

(First) (Middle) (Last)
Thomas Norris

4. DATE OF DEATH (Month) (Day) (Year)
Oct 19, 1955 19

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Married

8. DATE OF BIRTH:

June 26, 1875

9. AGE last birthday:

80 yrs

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Retired Employee of Balto. Co. Roads

10b. KIND OF BUSINESS OR INDUSTRY:

England

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

Thomas Norris

14. MOTHER'S MAIDEN NAME:

Jane Rickson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Margaret U. Norris, Reisterstown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

901.0
Immediate cause**(a) Fractured Skull (base)****DUE TO****Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last

(b) DUE TO**(c)**

INTERVAL BETWEEN ONSET AND DEATH
2 1/2 hrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

None

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

None**None**

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY **Home**

21c. (City or town) (County) (State)
Reisterstown Balto. Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **Oct 19 55 9:30 A.M.**

21e. INJURY OCCURRED While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR?
Fell from ladder while painting

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

A.D. CaplesCHIEF MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐M. D. ASSISTANT MEDICAL EXAM. ☐**10/24/55**

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Oct. 21/55

NAME OF CEMETERY OR CREMATORY

New Cathedral

LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE REC'D BY LOCAL REG.

10-21-55

REGISTRAR'S SIGNATURE

Mary B. Eline

24. FUNERAL DIRECTOR

J.F. Eline & Sons, Reisterstown, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 28 1965

BUREAU V. 2

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9516

CERTIFICATE OF DEATH

09511

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>53 Days</u>		TOWN <u>Annapolis</u>		<u>02-10-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1833 West Street</u>			
3. NAME OF DECEASED (Type or Print) <u>JEREMIAH O'BRIEN</u>				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>10-9-88</u>	
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Parts</u>		11. BIRTHPLACE (State or foreign country) <u>Kanturk Co. Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mullane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>097-03-3572</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>451X</u> IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC ANEURYSM OF PROXIMAL AORTA</u>							
ANTECEDENT CAUSE(S) <u>XXXXX</u> WITH SEVERE RELATIVE INSUFFICIENCY OF AORTIC							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>VALVE</u>						<u>UNKNOWN</u>	
(C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>VA</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 7, 1955</u>, to <u>Oct. 30, 1955</u>, the last day the deceased lived, and that death occurred at <u>12:35 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>			
DATE SIGNED <u>10-31-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Long Island National</u>		LOCATION (City, town, or county) (State) <u>Long Island, New York</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Lawson L. Farkley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Funeral Home, St. Paul & Preston Sts</u>			
DATE <u>Nov. 3, 1955</u>				ADDRESS <u>Baltimore, Maryland</u>			

CERTIFICATE OF DEATH

1951

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Signature of registrar

10. Signature of medical examiner

11. Signature of coroner

12. Date of filing

13. Place of filing

14. Signature of registrar

15. Signature of medical examiner

16. Date of death

17. Place of death

18. Signature of physician

19. Signature of registrar

20. Signature of medical examiner

21. Signature of coroner

22. Signature of physician

23. Signature of registrar

24. Signature of medical examiner

25. Signature of registrar

26. Signature of medical examiner

27. Signature of coroner

28. Date of filing

29. Place of filing

30. Signature of registrar

31. Signature of medical examiner

32. Date of death

33. Place of death

34. Signature of physician

35. Signature of registrar

36. Signature of medical examiner

37. Signature of coroner

38. Signature of physician

39. Signature of registrar

40. Signature of medical examiner

41. Signature of registrar

42. Signature of medical examiner

43. Signature of coroner

44. Date of filing

45. Place of filing

46. Signature of registrar

47. Signature of medical examiner

48. Date of death

49. Place of death

50. Signature of physician

51. Signature of registrar

52. Signature of medical examiner

53. Signature of coroner

54. Signature of physician

55. Signature of registrar

56. Signature of medical examiner

57. Signature of registrar

58. Signature of medical examiner

59. Signature of coroner

60. Date of filing

61. Place of filing

62. Signature of registrar

63. Signature of medical examiner

64. Date of death

65. Place of death

66. Signature of physician

67. Signature of registrar

68. Signature of medical examiner

69. Signature of coroner

70. Signature of physician

71. Signature of registrar

72. Signature of medical examiner

RECEIVED

BUREAU V. 3

RECEIVED
NOV 9 1951

9517

CERTIFICATE OF DEATH

Reg. Dist. No. 31

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		STATE <u>md</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hosp</u>		LENGTH OF STAY (in this place) <u>36 days</u>		STREET ADDRESS (If rural give location) <u>Corkysmill Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Condon Rhodes Orndorff</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 20 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 1, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Samper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Lumber</u>		11. BIRTHPLACE (State or foreign country): <u>Zepp, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jefferson Orndorff</u>				14. MOTHER'S MAIDEN NAME: <u>Willie Wymer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Army 219-14-6997</u>				16. SOCIAL SECURITY NO. <u>219-14-6997</u>			
17. INFORMANT & ADDRESS: <u>Mt. Wilson State Hosp. Records, Mt. Wilson, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>8 years</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 4, 1955</u> to <u>Oct. 20, 1955</u> that I last saw the deceased alive on <u>Oct. 20, 1955</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William M. D. Mt. Wilson Md.</u>				DATE SIGNED <u>Oct 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Zepp</u>		LOCATION (City, town, or county) (State) <u>Zepp, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Ann E. Martin</u>		24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz - Winfield, Md.</u>			

MARGIN RESERVED FOR BINDING

RECEIVED

NOV 2 1955

BUREAU V. A.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09513

9518 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>14</u> Hours		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3801.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1321 West Baltimore Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANTHONY</u> <u>PARKER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 25</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/8/17</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Mobile, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Parker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>211-05-3241</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
526X IMMEDIATE CAUSE (A) <u>PULMONARY EMPHYSEMA, CHRONIC</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO <u>BRONCHIECTASIS, CHRONIC</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>COR PULMONALE</u>						<u>UNKNOWN</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 24, 1955</u> to <u>October 25, 1955</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. G. Dickey, M.D.</u>				ADDRESS (Street, city, town, state) <u>FORT HOWARD MARYLAND</u>			
DATE THEREOF <u>Oct. 28, 1955</u>				DATE SIGNED <u>10-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>Oct. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave. Balto. Md.</u>	

1. This form is to be filled out by the attending physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and before the body is moved or buried. It should be filled out in the presence of the family, if possible, and the family should be given a copy of the certificate. The certificate should be kept in a safe place, and a copy should be given to the funeral home or other person who is responsible for the burial. The certificate should be filled out in the presence of the family, if possible, and the family should be given a copy of the certificate. The certificate should be kept in a safe place, and a copy should be given to the funeral home or other person who is responsible for the burial.

CERTIFICATE OF DEATH

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Manner of Death

6. Signature of Physician

7. Signature of Registrar

8. Signature of Family

9. Signature of Funeral Home

10. Signature of Other

11. Signature of Deceased

12. Signature of Witness

13. Signature of Coroner

14. Signature of Jury

15. Signature of Judge

16. Signature of Clerk

17. Signature of Sheriff

18. Signature of Marshal

19. Signature of Constable

20. Signature of Notary

21. Signature of Justice

22. Signature of Mayor

23. Signature of Councilman

24. Signature of Alderman

25. Signature of Commissioner

26. Signature of Governor

27. Signature of President

28. Signature of Vice President

29. Signature of Speaker

30. Signature of Minority Leader

31. Signature of Majority Leader

32. Signature of Chief Justice

33. Signature of Associate Justice

34. Signature of Circuit Justice

35. Signature of District Justice

36. Signature of County Justice

37. Signature of Municipal Justice

38. Signature of State Justice

39. Signature of Federal Justice

40. Signature of Supreme Justice

41. Signature of Chief of Police

42. Signature of Deputy Chief of Police

43. Signature of Sergeant

44. Signature of Detective

45. Signature of Patrolman

46. Signature of Traffic Officer

47. Signature of Crime Scene Investigator

48. Signature of Forensic Scientist

49. Signature of Medical Examiner

50. Signature of Pathologist

51. Signature of Anatomist

52. Signature of Radiologist

53. Signature of Surgeon

54. Signature of Physician Assistant

55. Signature of Nurse

56. Signature of Medical Student

57. Signature of Medical Resident

58. Signature of Medical Fellow

59. Signature of Medical Director

60. Signature of Medical Officer

61. Signature of Medical Captain

62. Signature of Medical Major

63. Signature of Medical Lieutenant

64. Signature of Medical Sergeant

65. Signature of Medical Corporal

66. Signature of Medical Private

67. Signature of Medical Staff Sergeant

68. Signature of Medical First Sergeant

69. Signature of Medical Second Sergeant

70. Signature of Medical Third Sergeant

71. Signature of Medical Fourth Sergeant

72. Signature of Medical Fifth Sergeant

73. Signature of Medical Sixth Sergeant

74. Signature of Medical Seventh Sergeant

75. Signature of Medical Eighth Sergeant

76. Signature of Medical Ninth Sergeant

77. Signature of Medical Tenth Sergeant

78. Signature of Medical Eleventh Sergeant

79. Signature of Medical Twelfth Sergeant

80. Signature of Medical Thirteenth Sergeant

81. Signature of Medical Fourteenth Sergeant

82. Signature of Medical Fifteenth Sergeant

83. Signature of Medical Sixteenth Sergeant

84. Signature of Medical Seventeenth Sergeant

85. Signature of Medical Eighteenth Sergeant

86. Signature of Medical Nineteenth Sergeant

87. Signature of Medical Twentieth Sergeant

88. Signature of Medical Twenty-first Sergeant

89. Signature of Medical Twenty-second Sergeant

90. Signature of Medical Twenty-third Sergeant

91. Signature of Medical Twenty-fourth Sergeant

92. Signature of Medical Twenty-fifth Sergeant

93. Signature of Medical Twenty-sixth Sergeant

94. Signature of Medical Twenty-seventh Sergeant

95. Signature of Medical Twenty-eighth Sergeant

96. Signature of Medical Twenty-ninth Sergeant

97. Signature of Medical Thirtieth Sergeant

98. Signature of Medical Thirty-first Sergeant

99. Signature of Medical Thirty-second Sergeant

100. Signature of Medical Thirty-third Sergeant

101. Signature of Medical Thirty-fourth Sergeant

102. Signature of Medical Thirty-fifth Sergeant

103. Signature of Medical Thirty-sixth Sergeant

104. Signature of Medical Thirty-seventh Sergeant

105. Signature of Medical Thirty-eighth Sergeant

106. Signature of Medical Thirty-ninth Sergeant

107. Signature of Medical Fortieth Sergeant

108. Signature of Medical Forty-first Sergeant

109. Signature of Medical Forty-second Sergeant

110. Signature of Medical Forty-third Sergeant

111. Signature of Medical Forty-fourth Sergeant

112. Signature of Medical Forty-fifth Sergeant

113. Signature of Medical Forty-sixth Sergeant

114. Signature of Medical Forty-seventh Sergeant

115. Signature of Medical Forty-eighth Sergeant

116. Signature of Medical Forty-ninth Sergeant

117. Signature of Medical Fiftieth Sergeant

118. Signature of Medical Fifty-first Sergeant

119. Signature of Medical Fifty-second Sergeant

120. Signature of Medical Fifty-third Sergeant

121. Signature of Medical Fifty-fourth Sergeant

122. Signature of Medical Fifty-fifth Sergeant

123. Signature of Medical Fifty-sixth Sergeant

124. Signature of Medical Fifty-seventh Sergeant

125. Signature of Medical Fifty-eighth Sergeant

126. Signature of Medical Fifty-ninth Sergeant

127. Signature of Medical Sixtieth Sergeant

128. Signature of Medical Sixty-first Sergeant

129. Signature of Medical Sixty-second Sergeant

130. Signature of Medical Sixty-third Sergeant

131. Signature of Medical Sixty-fourth Sergeant

132. Signature of Medical Sixty-fifth Sergeant

133. Signature of Medical Sixty-sixth Sergeant

134. Signature of Medical Sixty-seventh Sergeant

135. Signature of Medical Sixty-eighth Sergeant

136. Signature of Medical Sixty-ninth Sergeant

137. Signature of Medical Seventieth Sergeant

138. Signature of Medical Seventy-first Sergeant

139. Signature of Medical Seventy-second Sergeant

140. Signature of Medical Seventy-third Sergeant

141. Signature of Medical Seventy-fourth Sergeant

142. Signature of Medical Seventy-fifth Sergeant

143. Signature of Medical Seventy-sixth Sergeant

144. Signature of Medical Seventy-seventh Sergeant

145. Signature of Medical Seventy-eighth Sergeant

146. Signature of Medical Seventy-ninth Sergeant

147. Signature of Medical Eightieth Sergeant

148. Signature of Medical Eighty-first Sergeant

149. Signature of Medical Eighty-second Sergeant

150. Signature of Medical Eighty-third Sergeant

151. Signature of Medical Eighty-fourth Sergeant

152. Signature of Medical Eighty-fifth Sergeant

153. Signature of Medical Eighty-sixth Sergeant

154. Signature of Medical Eighty-seventh Sergeant

155. Signature of Medical Eighty-eighth Sergeant

156. Signature of Medical Eighty-ninth Sergeant

157. Signature of Medical Ninetieth Sergeant

158. Signature of Medical Ninety-first Sergeant

159. Signature of Medical Ninety-second Sergeant

160. Signature of Medical Ninety-third Sergeant

161. Signature of Medical Ninety-fourth Sergeant

162. Signature of Medical Ninety-fifth Sergeant

163. Signature of Medical Ninety-sixth Sergeant

164. Signature of Medical Ninety-seventh Sergeant

165. Signature of Medical Ninety-eighth Sergeant

166. Signature of Medical Ninety-ninth Sergeant

167. Signature of Medical One Hundredth Sergeant

168. Signature of Medical One Hundred-first Sergeant

169. Signature of Medical One Hundred-second Sergeant

170. Signature of Medical One Hundred-third Sergeant

171. Signature of Medical One Hundred-fourth Sergeant

172. Signature of Medical One Hundred-fifth Sergeant

173. Signature of Medical One Hundred-sixth Sergeant

174. Signature of Medical One Hundred-seventh Sergeant

175. Signature of Medical One Hundred-eighth Sergeant

176. Signature of Medical One Hundred-ninth Sergeant

177. Signature of Medical One Hundred-tenth Sergeant

178. Signature of Medical One Hundred-eleventh Sergeant

179. Signature of Medical One Hundred-twelfth Sergeant

180. Signature of Medical One Hundred-thirteenth Sergeant

181. Signature of Medical One Hundred-fourteenth Sergeant

182. Signature of Medical One Hundred-fifteenth Sergeant

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184. Signature of Medical One Hundred-seventeenth Sergeant

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186. Signature of Medical One Hundred-nineteenth Sergeant

187. Signature of Medical One Hundred-twentieth Sergeant

188. Signature of Medical One Hundred-twenty-first Sergeant

189. Signature of Medical One Hundred-twenty-second Sergeant

190. Signature of Medical One Hundred-twenty-third Sergeant

191. Signature of Medical One Hundred-twenty-fourth Sergeant

192. Signature of Medical One Hundred-twenty-fifth Sergeant

193. Signature of Medical One Hundred-twenty-sixth Sergeant

194. Signature of Medical One Hundred-twenty-seventh Sergeant

195. Signature of Medical One Hundred-twenty-eighth Sergeant

196. Signature of Medical One Hundred-twenty-ninth Sergeant

197. Signature of Medical One Hundred-thirtieth Sergeant

198. Signature of Medical One Hundred-thirty-first Sergeant

199. Signature of Medical One Hundred-thirty-second Sergeant

200. Signature of Medical One Hundred-thirty-third Sergeant

201. Signature of Medical One Hundred-thirty-fourth Sergeant

202. Signature of Medical One Hundred-thirty-fifth Sergeant

203. Signature of Medical One Hundred-thirty-sixth Sergeant

204. Signature of Medical One Hundred-thirty-seventh Sergeant

205. Signature of Medical One Hundred-thirty-eighth Sergeant

206. Signature of Medical One Hundred-thirty-ninth Sergeant

207. Signature of Medical One Hundred-fortieth Sergeant

208. Signature of Medical One Hundred-forty-first Sergeant

209. Signature of Medical One Hundred-forty-second Sergeant

210. Signature of Medical One Hundred-forty-third Sergeant

211. Signature of Medical One Hundred-forty-fourth Sergeant

212. Signature of Medical One Hundred-forty-fifth Sergeant

213. Signature of Medical One Hundred-forty-sixth Sergeant

214. Signature of Medical One Hundred-forty-seventh Sergeant

215. Signature of Medical One Hundred-forty-eighth Sergeant

216. Signature of Medical One Hundred-forty-ninth Sergeant

217. Signature of Medical One Hundred-fiftieth Sergeant

218. Signature of Medical One Hundred-fifty-first Sergeant

219. Signature of Medical One Hundred-fifty-second Sergeant

220. Signature of Medical One Hundred-fifty-third Sergeant

221. Signature of Medical One Hundred-fifty-fourth Sergeant

222. Signature of Medical One Hundred-fifty-fifth Sergeant

223. Signature of Medical One Hundred-fifty-sixth Sergeant

224. Signature of Medical One Hundred-fifty-seventh Sergeant

225. Signature of Medical One Hundred-fifty-eighth Sergeant

226. Signature of Medical One Hundred-fifty-ninth Sergeant

227. Signature of Medical One Hundred-sixtieth Sergeant

228. Signature of Medical One Hundred-sixty-first Sergeant

229. Signature of Medical One Hundred-sixty-second Sergeant

230. Signature of Medical One Hundred-sixty-third Sergeant

231. Signature of Medical One Hundred-sixty-fourth Sergeant

232. Signature of Medical One Hundred-sixty-fifth Sergeant

233. Signature of Medical One Hundred-sixty-sixth Sergeant

234. Signature of Medical One Hundred-sixty-seventh Sergeant

235. Signature of Medical One Hundred-sixty-eighth Sergeant

236. Signature of Medical One Hundred-sixty-ninth Sergeant

237. Signature of Medical One Hundred-seventieth Sergeant

238. Signature of Medical One Hundred-seventy-first Sergeant

239. Signature of Medical One Hundred-seventy-second Sergeant

240. Signature of Medical One Hundred-seventy-third Sergeant

241. Signature of Medical One Hundred-seventy-fourth Sergeant

242. Signature of Medical One Hundred-seventy-fifth Sergeant

243. Signature of Medical One Hundred-seventy-sixth Sergeant

244. Signature of Medical One Hundred-seventy-seventh Sergeant

245. Signature of Medical One Hundred-seventy-eighth Sergeant

246. Signature of Medical One Hundred-seventy-ninth Sergeant

247. Signature of Medical One Hundred-eightieth Sergeant

248. Signature of Medical One Hundred-eighty-first Sergeant

249. Signature of Medical One Hundred-eighty-second Sergeant

250. Signature of Medical One Hundred-eighty-third Sergeant

251. Signature of Medical One Hundred-eighty-fourth Sergeant

252. Signature of Medical One Hundred-eighty-fifth Sergeant

253. Signature of Medical One Hundred-eighty-sixth Sergeant

254. Signature of Medical One Hundred-eighty-seventh Sergeant

9392

CERTIFICATE OF DEATH

Reg. Dist. No. *for*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Relay		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Relay			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1536 Rolling Rd				STREET ADDRESS (If rural, give location) 1536 Rolling Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last) Elizabeth K. Patterson				4. DATE OF DEATH: (Month) (Day) (Year) 10-19-55			
5. SEX: female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow		9. AGE last birthday: 94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY: home		11. BIRTHPLACE (State or foreign country): Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Hamilton Riell				14. MOTHER'S MAIDEN NAME: Rose Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Helen McHale, 1538 Rolling Rd.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause (a) Generalized Arteriosclerosis DUE TO						Unknown	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 49 , to Oct. 19 , 19 55 , that I last saw the deceased alive on Oct. 17 , 19 55 , and that death occurred at 11:20 A.M. , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i> M. D.				ADDRESS 1 Talow Hill Ave., Baltimore, Md		DATE SIGNED 10/21/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 10-22-55		NAME OF CEMETERY OR CREMATORY Loudon Par		LOCATION (City, town, or county) (State) Baltimore	
DATE RECD BY LOCAL REG. 10/22/55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 24 1955

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

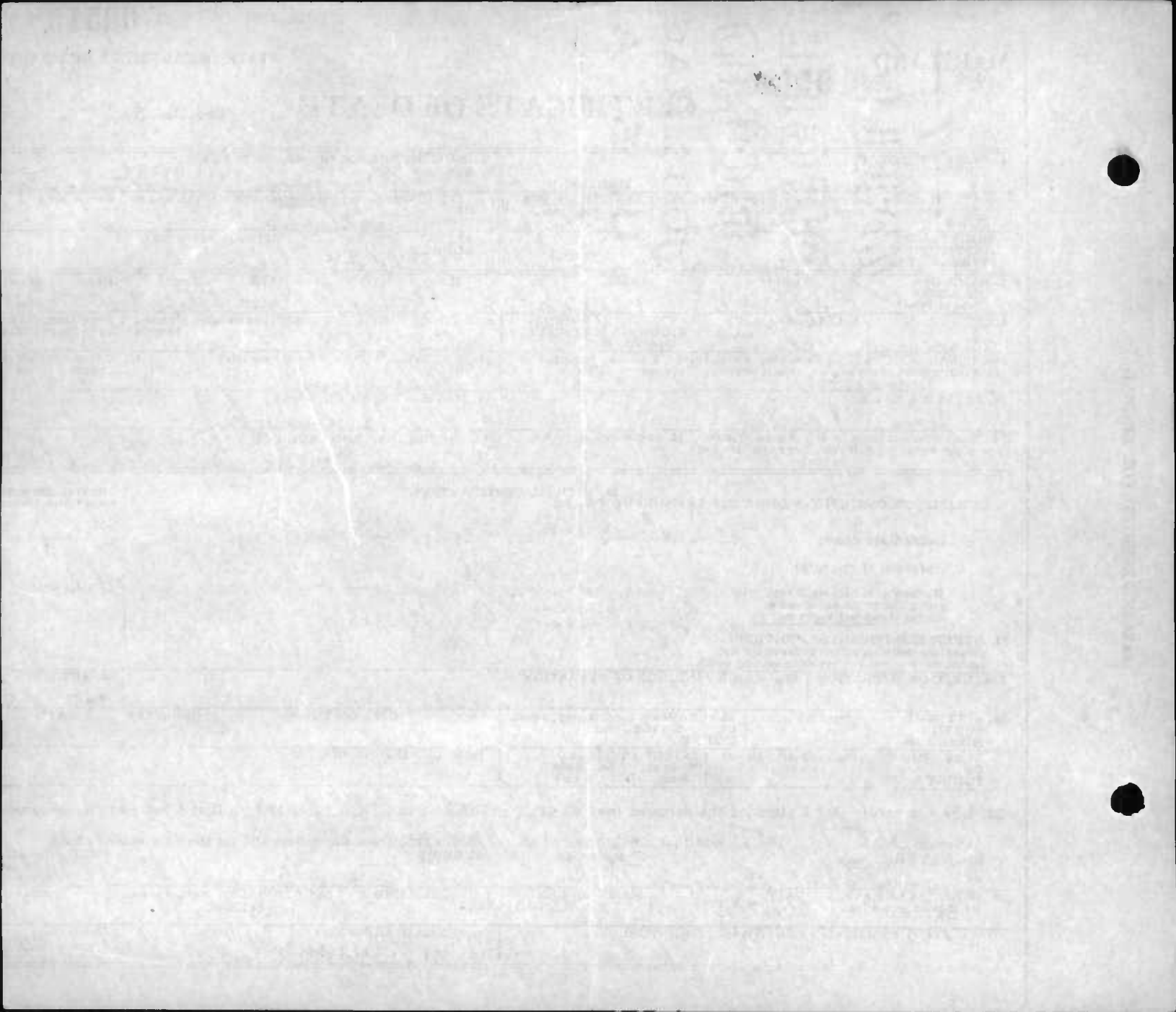
9519

CERTIFICATE OF DEATH

Reg. Dist. No. 33

Item 8, Film G188 10-28-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 <u>Berryman Lane</u>		STREET ADDRESS (If rural, give location) <u>1824 Wilkins Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARGARET ELIZABETH PENSEL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 19 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 27 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hours Hours Min
11. FATHER'S NAME <u>John Pense</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Marie Kuebel</u>		14. INFORMANT AND ADDRESS <u>Mrs. Marie Kuebel, Reisterstown, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X Immediate cause (a) <u>Cerebral Vascular Accident</u>		8 days	
Antecedent cause(s) (b) <u>Pneumonia broncho bilateral</u>		3 days	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive C.V. Disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 6</u> , 19 <u>55</u> , to <u>Oct 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 19</u> , 19 <u>55</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Blanche E. McWilliams M.D.</u>		ADDRESS <u>Reisterstown, Maryland</u> DATE SIGNED <u>Oct 19 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>10/22/55</u> NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u> LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REG. <u>20-55</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balto., Md.</u> 24. FUNERAL DIRECTOR ADDRESS	



9520

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>FORT HOWARD</u>		<u>3 DAYS</u>		TOWN <u>BALTIMORE</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 VETERANS ADMINISTRATION HOSPITAL</u>				<u>237 N. GILMORE STREET</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>RONIOUS (NMI) PERRY</u>				<u>OCTOBER 1 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLORED</u>	<u>DIVORCED</u>	<u>7/18/10</u>	<u>45</u> yrs.	Months	Days	Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>CONTRACTOR WORK</u>		<u>WALSTONBURG, N.C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>EDD PERRY</u>				<u>ANNIE WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>YES</u> <u>WW-II</u>				<u>244 16 5913</u>		<u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>490X</u>						<u>10 DAYS</u>	
IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B) DUE TO	
						(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>PANCREATITIS, ACUTE SECONDARY TO ABOVE</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>SEPT 28, 19 55</u> to <u>OCT. 1, 19 55</u> and that death occurred at <u>10:10M.</u> from the causes and on the date stated above.							
A. ADDRESS						DATE SIGNED	
<u>VAH, FORT HOWARD, MARYLAND</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10/5/55</u>		<u>BALTIMORE NATIONAL CEMETERY</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10 3 55</u>		<u>[Signature]</u>		<u>CHARLES R. LAW FUNERAL HOME</u>		<u>802 MADISON AVE. BALTIMORE, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

09517

2411 N. Charles Street, Baltimore

9521

CERTIFICATE OF DEATH

Reg. Dist. No. 31

Item 9, Film 188 11-1-55 et

1. PLACE OF DEATH- COUNTY <u>Balt</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u> LENGTH OF STAY (in this place) <u>2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>3533 Wild Cherry Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u> (Middle) <u>Rinder</u> (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 24</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Apr 24, 1860</u> 9. AGE last birthday <u>95</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Samuel Chapera 3533 Cherry</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
Immediate cause <u>140X</u> (a) <u>Pneumonia of left lung</u>			
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>11-1-55</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 1, 1955, to Oct 24, 1955, that I last saw the deceased alive on Oct 23, 1955, and that death occurred at 12:05 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial 10-26-55 Woodlawn Balt md

24. FUNERAL DIRECTOR ADDRESS

Forrest Byers 5005 Park Ave Balt 15, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6222

9522

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE PENNSYLVANIA		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD		101 DAYS		TOWN PHILADELPHIA 75X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
VETERANS ADMINISTRATION HOSPITAL				1939 ELSTON STREET			
3. NAME OF DECEASED: (First (Middle) (Last))				4. DATE (Month) (Day) (Year) OF DEATH:			
JOHN (NMI) PINKERTON				OCTOBER 20 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	1-28-1888	67 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
SHIPPING CLERK				MEAT CO.		PATERSON, NEW JERSEY	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
GEORGE PINKERTON				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
YES WW I				159-18-0139		CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) LYMPHOSARCOMA						UNKNOWN	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
5/9/55				THORACIC LAMINECTOMY WITH PARTIAL REMOVAL OF TUMOR			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JULY 11, 1955 , to OCT. 20, 1955 , that I last saw the deceased 6:10 AM , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
WILLIAM B. VANDEGRIFT				M. D. VAH FT. HOWARD, MD		10/20/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		10-20-55		HOLY SEPULCHURE CEMETERY		PATERSON, NEW JERSEY	
24. FUNERAL DIRECTOR		ADDRESS					
WM. COOK-BLIGHT INC		6009 HARBOR RD		BALTIMORE, MD			
SHIPPED TO: James Murray Funeral Home, Chelton Ave. & Sprague St. Philadelphia, Pennsylvania							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 24 1955

BUREAU V. B.

9523

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH: Sheppard-Pratt Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
55 TOWN Towson		4 1/2 yrs.		TOWN Baltimore		3401-4	
13 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard and Enoch Pratt Hospital				STREET ADDRESS (If rural give location) 2602 Elsinore Ave. - 16			
3. NAME OF DECEASED: (Type or Print)		(First) Lillian		(Middle) May		(Last) PITTS	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed		8. DATE OF BIRTH: Oct. 6, 1871	
9. AGE last birthday: 84 yrs.		4. DATE OF DEATH: October 22, 1955		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME: James T. Mitchell		14. MOTHER'S MAIDEN NAME: Grace Baldwin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No	
16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Hospital Records		18. MEDICAL CERTIFICATION		Interval Between Onset And Death	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
422.1 Immediate cause (a) Cerebral thrombosis DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized arteriosclerosis and chronic myocarditis. DUE TO		
(c)		4 years plus

II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr. 10, 1951, to Oct. 22, 1955, that I last saw the deceased

alive on Oct. 21, 1955, and that death occurred at 3:30 a.m. from the causes and on the date stated above.

SIGNATURE: M. J. Melvin, M.D. Asst. Med. Supt. ADDRESS: Sheppard-Pratt Hosp. DATE SIGNED: 10/22/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	10/25/55	Green Mount Cem.	Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	

10/24/55 A. W. Hadrich M. J. Melvin & Sons Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9100

RECEIVED

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Reg. Dist. 43

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>FULLERTON</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>292 Ridge Pt.</u>		STREET ADDRESS (If rural, give location) <u>104 292 Ridge Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Amelia</u>	(Middle)	(Last) <u>Prescoe</u>	(Month) <u>Oct</u> (Day) <u>3</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct 16/1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	9. AGE last birthday: <u>78</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ind.</u>	
13. FATHER'S NAME: <u>Henry Prescoe</u>		14. MOTHER'S MAIDEN NAME: <u>Mary (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>1</u>		16. SOCIAL SECURITY No.: <u>1</u>	
17. INFORMANT & ADDRESS: <u>Laura Johnson (sister)</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
420.1 Immediate cause (a) <u>Cerebral occlusion</u>		<u>Ant. nom.</u>
Antecedent cause(s) (b) <u>Cor. Vascular Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	

21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF DEATH: <u>Oct 3 55. 8 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>3R</u>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Wm. H. M. D. M. D. DATE SIGNED: 10-6-55

23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>10-6-55</u>		NAME OF CEMETERY OR CREMATORY: <u>ARbutus M.E.M. PK</u>		LOCATION (City, town, or county) (State): <u>ARbutus, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-55</u>		REGISTRAR'S SIGNATURE: <u>Dr. Redick</u>		24. FUNERAL DIRECTOR: <u>Joseph E. Rocks</u>		ADDRESS: <u>1304 N. Central St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE DEPARTMENT OF THE ARMY

NOV 14 1914

TO THE SECRETARY OF THE ARMY, WASHINGTON, D. C.

OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
NOV 14 1914

Very respectfully,
Yours truly,
[Signature]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9525

CERTIFICATE OF DEATH

Reg. Dist. No. 9521 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Ma.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cockeysville</u>	LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Sherwood Road.</u>	STREET ADDRESS (If rural give location) <u>1 Sherwood Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>George Edward Price</u>		OF DEATH: <u>Oct. 18</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>August 5, 1914</u>
9. AGE last birthday <u>71</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Labourer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>John Price</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME: <u>McKuberson</u>		17. INFORMANT & ADDRESS: <u>Cockeysville daughter; Mrs. Mary Howard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>526X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Acute pulmonary edema</u>			<u>4 hrs.</u>
(B) <u>Con pulmonary</u>			<u>years.</u>
(C) <u>Chronic bronchiectasis</u>			<u>"</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1950</u> to <u>Oct 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 18</u> , 19 <u>55</u> , and that death occurred at <u>5 A.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Elizabeth B. Sherrill</u>		ADDRESS <u>Cockeysville Ma.</u>	
DATE SIGNED <u>10/18/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>10-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Episcopal Methodist</u>		LOCATION (City, town, or county) (State) <u>Sparks, Baltco. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. Whitcraft</u>	
		24. FUNERAL DIRECTOR <u>Brooks Funeral Service</u>	
		ADDRESS <u>Sparks, Md.</u>	

BUREAU V. S.

OCT 20 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09522

9526

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Lochearn		CITY (If outside corporate limits, write RURAL and give nearest town) Lochearn	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3700 Oak Ave.		STREET ADDRESS (If rural, give location) 3700 Oak Ave.	
3. NAME OF DECEASED (Type or Print) George	(First) Lucius	(Middle) Price	(Last)
4. DATE OF DEATH October 6	(Month)	(Day)	(Year) 1955
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 15, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 64 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank S. Price		14. MOTHER'S MAIDEN NAME Louise Simmons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give was or dates of service) World War I		16. SOCIAL SECURITY NO. 317-05-5045	
17. INFORMANT AND ADDRESS 321 72nd St.		17. INFORMANT AND ADDRESS Mrs. Louise Whitworth, Newport News Va.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Obstructive jaundice		1 wk.
Antecedent cause(s) (b) Cause unknown.		1 wk.
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.		
19a. DATE OF OPERATION None.	19b. MAJOR FINDINGS OF OPERATION None.	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None.	PLACE (Home, farm, factory, street, office bldg., etc.) None.	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> None.	HOW DID INJURY OCCUR? None.
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE D. D. Caples Deputy Med. Exam. M. D.		DATE SIGNED 10-7-55
ADDRESS Reisterstown, Md		
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF October 9, 1955	NAME OF CEMETERY OR CREMATORY Knoll Kreg
LOCATION (City, town, or county) Abingdon, Virginia	(State)	
DATE REC'D BY LOCAL REG. Oct 7, 1955	REGISTRAR'S SIGNATURE Harvey G. Murrell	24. FUNERAL DIRECTOR Frank H. Murrell, Parkersville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 11 1965

RECEIVED

09523

MARYLAND

STATE DEPARTMENT OF HEALTH

9527

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Adedale</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7407 Brightside Avenue				STREET ADDRESS 7407 Brightside Avenue		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) Mr. William Jackson		(First) (Middle) (Last) Proffitt		4. DATE OF DEATH October 10th 1955		(Month) (Day) (Year)	
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH Feb. 1, 1893	
				9. AGE last birthday 62 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter - Prop. S. S. Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tye River, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Thomas Jackson Proffitt				14. MOTHER'S MAIDEN NAME Laura Litchford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 231-03-9707		17. INFORMANT AND ADDRESS Mrs. Myrtle S. Proffitt, 7407 Brightside Av			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Chronic Rheumatic Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b).....

(c).....

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not While Work At work

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from 11-1943, to 10-10-1955, that I last saw the deceased

alive on 10-10-1955, and that death occurred at 9:05 P.m., from the causes and on the date stated above.

SIGNATURE

N. J. Dainoff (Degree or title)

ADDRESS

DATE SIGNED

3218 Eastern ave Baltimore 24 Md

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE

Oct. 13 1955

NAME OF CEMETERY OR CREMATORY

Harford Mem PK

LOCATION (City, town, or county)

Balto. Md

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

A. W. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road #14

MARGIN RESERVED FOR BINDING

Dr. Davidou
3218 Eastern Ave.
DI 2 3030

10-12

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09524

9528

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Balto.	STATE	Md.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Catonsville	COUNTY	A. A.
52 TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Gambrill
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Wayne Convalescent Home	STREET ADDRESS	St. Stephens Rd.
3. NAME OF DECEASED:	(First) MAMIE	(Middle) C,	(Last) REDDIN
4. DATE (Month) OF DEATH:	Oct.	(Day) 7,	(Year) 19 55
5. SEX:	female	6. COLOR OR RACE:	white
7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify):	widowed	8. DATE OF BIRTH:	Dec. 7, 1879
9. AGE last birthday	75 yrs.	IF UNDER 1 YEAR	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	homemaker	10B. KIND OF BUSINESS OR INDUSTRY:	at home
11. BIRTHPLACE (State or foreign country):	Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:	Thomas M. Green	14. MOTHER'S MAIDEN NAME:	Sarah A. Hooper
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	no	16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS:	Mrs. O. D. Howe - Glen Burnie, Md.		
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)			Generalized Arteriosclerosis
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1955, to 1955, that I last saw the deceased alive on 7 Oct 1955, and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
J. H. Math A.D.		1707 Edmondson Ave	8 Oct 55
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	10/10/55	Green Mount Cem.	Balto., Md.
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
10/10/55			Wm J. Dickman & Sons, Balto 17 Md.

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

WASHINGTON, D.C. 20462

TELEPHONE (202) 455-5000

TELETYPE (202) 455-5000

FACSIMILE (202) 455-5000

MAIL ROOM (202) 455-5000

RECORDS MANAGEMENT (202) 455-5000

GENERAL INQUIRIES (202) 455-5000

FOR INFORMATION: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

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FOR ASSISTANCE: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

FOR ASSISTANCE: (202) 455-5000

9393

09525

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>Mass</i>	COUNTY <i>58 X-3</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
51 TOWN <i>Acushnet</i>	<i>5 days</i>	TOWN <i>Springfield</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<i>5378 Thomas an</i>		<i>16 Roosevelt an</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>William</i>	(Middle) <i>J</i>	(Last) <i>Reid Jr</i>	(Month) <i>Oct</i> (Day) <i>20</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
		<i>Married</i>	<i>July 9 1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday:	11. BIRTHPLACE (State or foreign country):
<i>Cable splicer</i>	<i>Telephone</i>	<i>59</i> yrs.	<i>Mass.</i>
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	12. CITIZEN OF WHAT COUNTRY?	
<i>William J Reid</i>	<i>Mary Castle</i>	<i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
(If Yes, give war or dates of service)		<i>Mrs Betty Reid 16 Roosevelt an Springfield Ma</i>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>420.1</i> <i>Coronary thrombosis</i> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Dr McKieffer</i>	1610 Leedson	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>OCT 20, 55</i>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Removal</i>	<i>OCT 20, 55</i>	<i>Hillcrest Cem</i>	<i>Springfield Mass</i>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>OCT 20 55</i>	<i>Dr McKieffer</i>	<i>Harry H Fritzke</i>	<i>44101 Edmonds an</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09526

9394

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town) 51 LANSDOWNE	LENGTH OF STAY (in this place) 20 YRS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LANSDOWNE	51
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 301 FOURTH AVE.		STREET ADDRESS (If rural give location) 301 FOURTH AVE	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) GEORGE	(Middle) REINHARD (Last) SR.	OF DEATH: OCT. 4 1955	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED	8. DATE OF BIRTH: DEC. 12, 1898
9. AGE last birthday: 56 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POSTAL CLERK RAILWAY EXPRESS.		10B. KIND OF BUSINESS OR INDUSTRY: NEW YORK	
11. BIRTHPLACE (State or foreign country): NEW YORK		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: JACOB H. REINHARDT		14. MOTHER'S MAIDEN NAME: MARY E. STRASSER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service) WIN I		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS: EDITH M. REINHARDT 301 FOURTH AVE			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 420.1 Acute Coronary Occlusion		10 minutes	
ANTECEDENT CAUSE (B) Essential Hypertension		10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Coronary Sclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: Nov 1945		19B. MAJOR FINDINGS OF OPERATION: Bilateral Sympathectomy for Essential Hypertension	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 1955 , to Oct. 4, 1955 that I last saw the deceased alive on Sept 6, 1955 , and that death occurred at 10:20 P.M. from the causes and on the date stated above.			
SIGNATURE Earl Pass, M.D.		DATE SIGNED 10-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10-7-55	
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-6-55		REGISTRAR'S SIGNATURE Joseph J. [Signature]	
24. FUNERAL DIRECTOR		ADDRESS 1324 Sulphur Sp. Rd.	

1944
J. H. Thompson

Wm I. Thompson
John H. Thompson

John H. Thompson
Wm I. Thompson

John H. Thompson
Wm I. Thompson

John H. Thompson
Wm I. Thompson

John H. Thompson
Wm I. Thompson

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09527

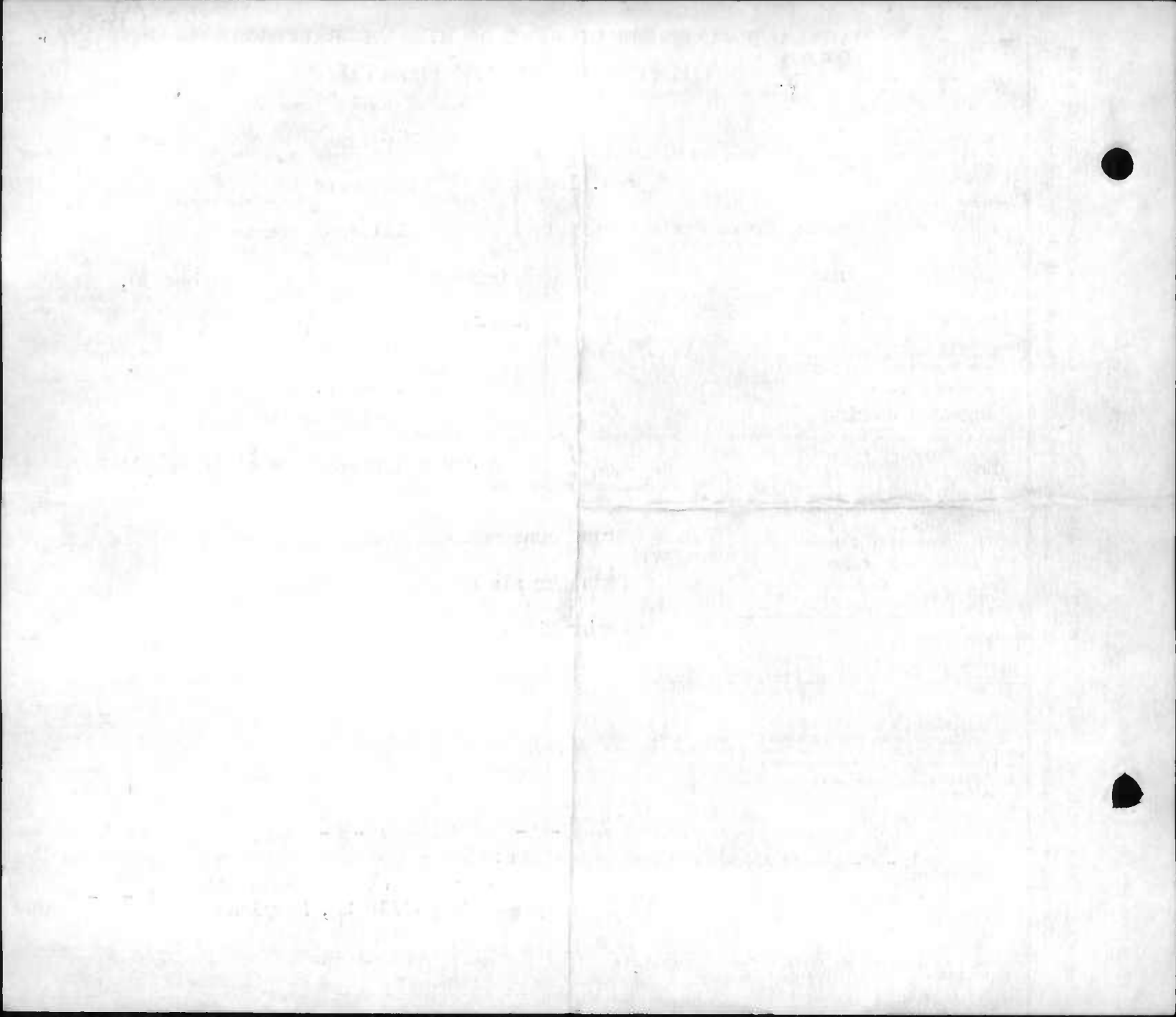
9529

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 12, Film GL89 11-16-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>3 mos. 15 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 19</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>2111 Anna Avenue</u> 1	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna Reisinger</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>October 30, 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-21-1883</u>
9. AGE last birthday <u>72</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>August Powering</u>		14. MOTHER'S MAIDEN NAME: <u>Dorothy Toulke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>			
ANTECEDENT CAUSE (B) <u>Pyonephrosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Nephrolithiasis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-15-1955</u> , to <u>10-30-1955</u> that I last saw the deceased alive on <u>10-30-1955</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Spella Wachler</u>		M. D. <u>Spring Grove State Hospital</u> DATE SIGNED <u>10-31-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Nov. 2, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> ADDRESS <u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/1/55</u>	REGISTRAR'S SIGNATURE <u>W. Hedrick</u>	24. FUNERAL DIRECTOR ADDRESS <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>	



9530

CERTIFICATE OF DEATH

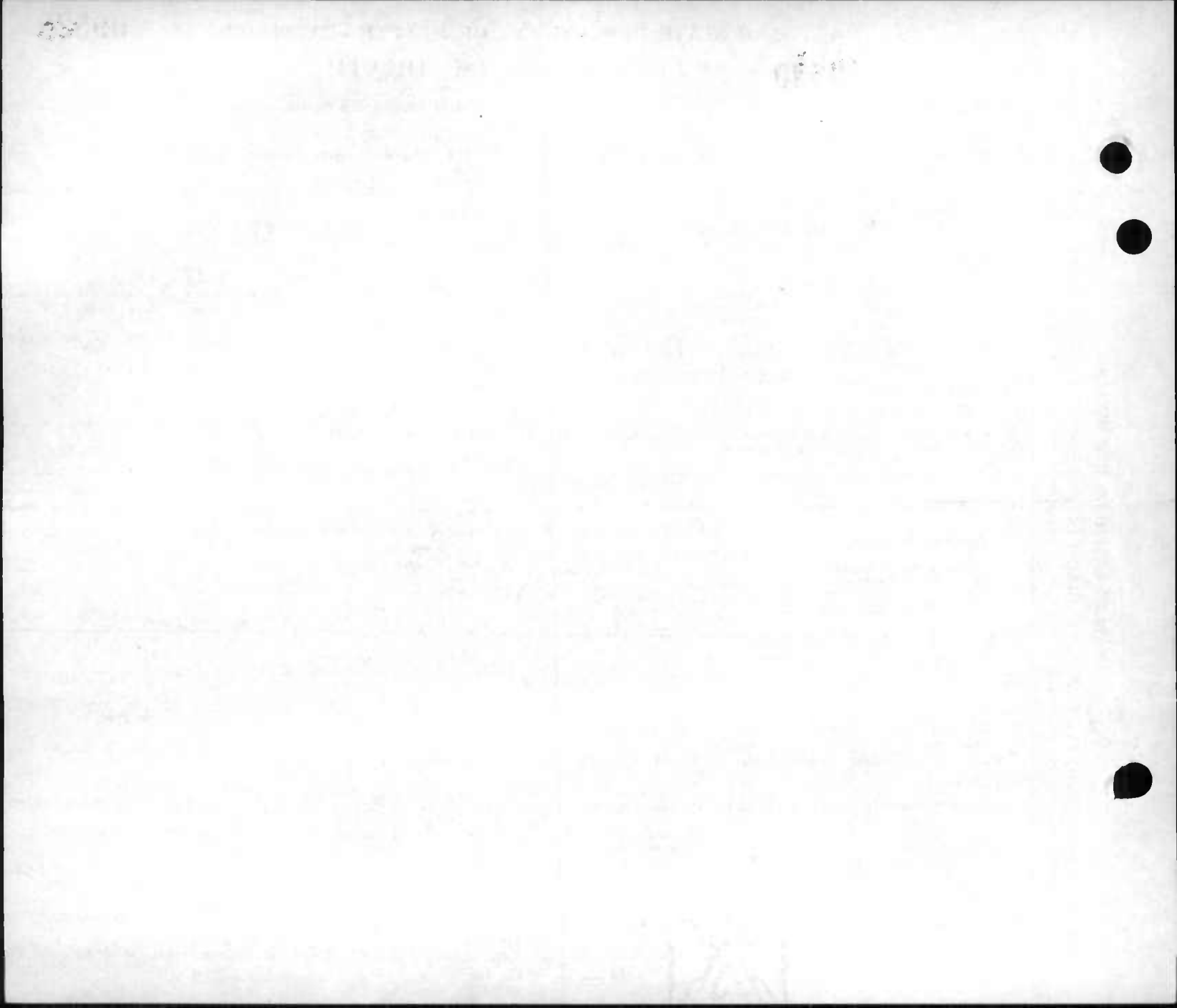
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL OR and give nearest town)		3401.4	
X TOWN Parkville				TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3009 Acton Road.				STREET ADDRESS (If rural give location) 3203 Leaverton Ave.			
3. NAME OF DECEASED: (First) CHARLES (Middle) (Last) RESCH				4. DATE OF DEATH: (Month) (Day) (Year) Oct. 17, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: April 12, 1871	
				9. AGE last birthday: 84 yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Wagon driver		10b. KIND OF BUSINESS OR INDUSTRY: Brewery		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Michael Resch				14. MOTHER'S MAIDEN NAME: Don't know			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY No.: ---		17. INFORMANT & ADDRESS: Miss Rose Resch 3203 Leaverton Ave.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>199.9 Immediate cause (a) Carcinomatous Obstruction - ile</p> <p>Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) to live - obstruction of intestines</p> <p>(c) Calculus, Malnutrition, Hemorrhage</p>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. generalized arteriosclerosis							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 15, 1955 , to Oct 17, 1955 , that I last saw the deceased alive on Oct 15, 1955 , and that death occurred at 6:45 AM from the causes and on the date stated above.							
SIGNATURE Donald W. Mintz		(Degree or title) MD		ADDRESS 3009 Evergreen Ave Parkville		DATE SIGNED Oct 17 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 20, 1955		Parkwood		Parkville, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10-18-55		W. J. Schuch		Ullrich Funeral Home		4210 Belair Road,	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9531

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Anneslie</u>				OR TOWN <u>Anneslie</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 Murdock Rd.</u>				STREET ADDRESS (If rural give location) <u>515 Murdock Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>PAULINE M. RICHARDSON</u>				<u>Oct. 12, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>diowed</u>	<u>Aug. 14, 1899</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>Insurance</u>		<u>Md.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Lewis B. Eyler</u>				<u>Mary S. Eyler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u> (If Yes, give war or dates of service)				<u>Mrs. Ethel E. Coster - 515 Murdock Rd.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Terminal bronchopneumonia</u>						<u>1 da.</u>	
ANTECEDENT CAUSE (B) <u>Artemia</u>						<u>1 wk.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Acute pyelonephritis</u>						<u>3 mos.</u>	
(C) <u>Recurrent carcinoma of rectum</u>						<u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma of rectum removed 5 yrs. ago.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>July 1950</u>		<u>Carcinoma of rectum, removed.</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Oct. 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>55</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Doct. B. Wright M.D.</u>		M. D. <u>Maxwell A. Bell</u>		DATE SIGNED <u>10/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/15/55</u>		<u>Woodlawn Cem.</u>		<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/14/55</u>		<u>Wm. J. Schenck</u>		<u>Wm. J. Schenck & Sons</u>		<u>Balto 17 Md</u>	

9532

CERTIFICATE OF DEATH

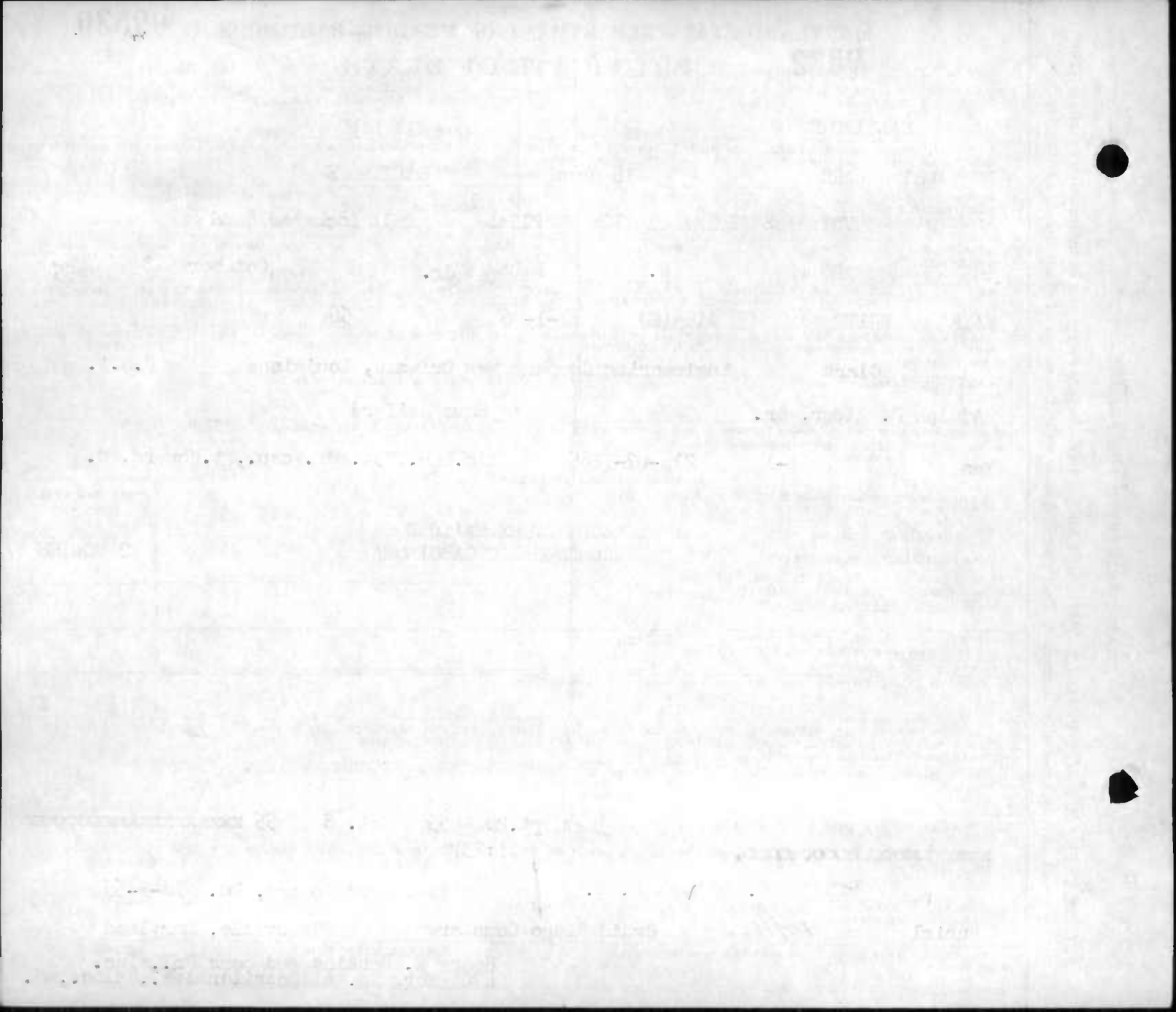
Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN FORT HOWARD	LENGTH OF STAY (in this place) 18 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 1531 Lochwood Road	
3. NAME OF DECEASED: (First) (Middle) (Last) ADOLPH H. RIDER Jr.		4. DATE (Month) (Day) (Year) OF DEATH October 8 1955	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 12-1-96
9. AGE last birthday 58 yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Engineering Company	
11. BIRTHPLACE (State or foreign country): New Orleans, Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Adolph H. Rider, Sr.		14. MOTHER'S MAIDEN NAME: Edna Raiford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 216-07-5285	
17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) RESPIRATORY FAILURE		2 MONTHS	
ANTECEDENT CAUSE (S) BRONCHOGENIC CARCINOMA			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 20, 1955 to Oct. 8, 1955 , and that death occurred at 11:23 PM , from the causes and on the date stated above.			
SIGNATURE Winston C. Dudley, M. D.		ADDRESS VAH, Fort Howard, Md.	
DATE SIGNED 10-9-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/11/55	
NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		LOCATION (City, town, or county) (State) Pikesville, Maryland	
DATE REC'D BY LOCAL REGISTRAR 10-7-55		REGISTRAR'S SIGNATURE Henry W. Jenkins and Sons Col., Inc.	
24. FUNERAL DIRECTOR 4905 York Rd. at Rossiter Ave., Balto., Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9533

09531

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Jones Creek (19) Life</u> TOWN <u>Jones Creek (19) Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7338 WALDMAN AVE</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>BALTIMORE</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>BALTIMORE (Jones Creek)</u> TOWN <u>BALTIMORE (Jones Creek)</u> STREET ADDRESS (If rural, give location) <u>7338 WALDMAN AVE</u>			
3. NAME OF DECEASED: (Type or Print) <u>RAYMOND CHARLES RIFFEL</u> (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>10 29 19 55</u>				
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>10-2-55</u>	9. AGE last birthday: yrs. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>			
13. FATHER'S NAME: <u>ARTHUR T. RIFFEL</u>			14. MOTHER'S MAIDEN NAME: <u>CARRIE V. SHRIVER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>A.T. RIFFEL - Same</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>7540</u> Immediate cause (a) <u>Consensual heart disease (probably due to</u> <u>lethal dose of Talbot)</u> Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause (c) <u>—</u> stating underlying cause last					INTERVAL BETWEEN ONSET AND DEATH <u>27 days</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Jack O. Hallin</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-30-55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>10-31-55</u>		NAME OF CEMETERY OR CREMATORY: <u>BALTO. NATIONAL</u>			
DATE REC'D BY LOCAL REG.: <u>Oct. 31-55</u>		REGISTRAR'S SIGNATURE: <u>Lawson L. Lasker</u>		24. FUNERAL DIRECTOR: <u>Walter Arthur Bradley, Dundalk, Md.</u>			
ADDRESS: <u>—</u>							

TWO FOR ONE CERTIFICATE
FIRM 6188 - 11/7/55 - Mnt.

BUREAU V. S.

NOV 9 1955

RECEIVED

9534

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RIPERWOOD</u>		LENGTH OF STAY (in this place) <u>Six days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Sorenson Ruxway Nursing Home</u>				STREET ADDRESS (If rural give location) <u>2 BLINKER COURT</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MINNIE</u> <u>RIFFLE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>October 22</u> <u>1955</u>			
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>FEB. 28, 1901</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>THOMAS MC CORD</u>				14. MOTHER'S MAIEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>FAMILY RECORDS</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199.1 IMMEDIATE CAUSE		(A) <u>metastasis of Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH		<u>day & death</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>malignancy face and neck</u>				<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>General Carcinomatosis</u>				<u>1 year</u>	
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no accident</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 17, 1955</u> , to <u>Oct. 22, 1955</u> , that I last saw the deceased alive on <u>Oct. 20, 1955</u> , and that death occurred at <u>10:40 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James Graham Harrison</u>		ADDRESS <u>516 Cathedral St</u>		DATE SIGNED <u>October 25, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Oct. 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Way's Chapel Cem.</u>		LOCATION (City, town, or county) (State) <u>Timonium, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9385

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09533

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Calverton	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN DUNDALK		13 MONTHS		TOWN 110 WILLIAMS AVE 53			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave. West of North Point Road				STREET ADDRESS (If rural, give location) DUNDALK 22, MD.			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
HARRY		LYNDON		Robinson			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE		8. DATE OF BIRTH: AUG. 8, 1932	
						9. AGE last birthday: 23 yrs.	
						4. DATE OF DEATH October 14 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): LABORER		10b. KIND OF BUSINESS OR INDUSTRY: STEEL MFR.		11. BIRTHPLACE (State or foreign country): N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME: HARRY R. ROBINSON				14. MOTHER'S MAIDEN NAME: BERTHA SHACKLEFORD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES		(If Yes, give war or dates of service) -UNK-		16. SOCIAL SECURITY No.: 237-52-6552		17. INFORMANT & ADDRESS: SAMUEL SPRY - SAME ADDRESS	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
823X Immediate cause (a) Multiple Traumatic Injuries DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street		21c. (City or town) Baltimore (County) Baltimore (State) Maryland			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Speeding auto - out of control			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Green		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED 10/14/55	
		M. D. ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF 10-18-55		NAME OF CEMETERY OR CREMATORY UNKNOWN		LOCATION (City, town, or county) (State) ANRORA, N.C.	
DATE REC'D BY LOCAL REG. 10-17-55		REGISTERAR'S SIGNATURE Edith Hurley		24. FUNERAL DIRECTOR Walter White Bradley Dundalk, Md.		ADDRESS	

RECEIVED

OCT 18 1955

BUREAU V. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Former Residence 3603 Enoch Ave
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

9535

CERTIFICATE OF DEATH

09534

Reg. Dist. No. 32

Item 9, Film G188 10-26-55 et

1. PLACE OF DEATH COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>3603 E</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Ugsburg Home</u>				STREET ADDRESS <u>3003 Enoch (in rural, give location) 6811 Oakfield Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret M. Roemer</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>Oct 9 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 1, 1871</u>	9. AGE last birthday <u>77</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
13. FATHER'S NAME <u>Wegand C. Stoll</u>		14. MOTHER'S MAIDEN NAME <u>Anna B. Stoll</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Records Ugsburg Home</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) <u>Cerebral Hemorrhage</u>	<u>3 wks.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arterio - Sclerotic Heart Disease</u>	<u>- 2 yrs.</u>
(c) <u>Generalized Arterio - Sclerotic</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

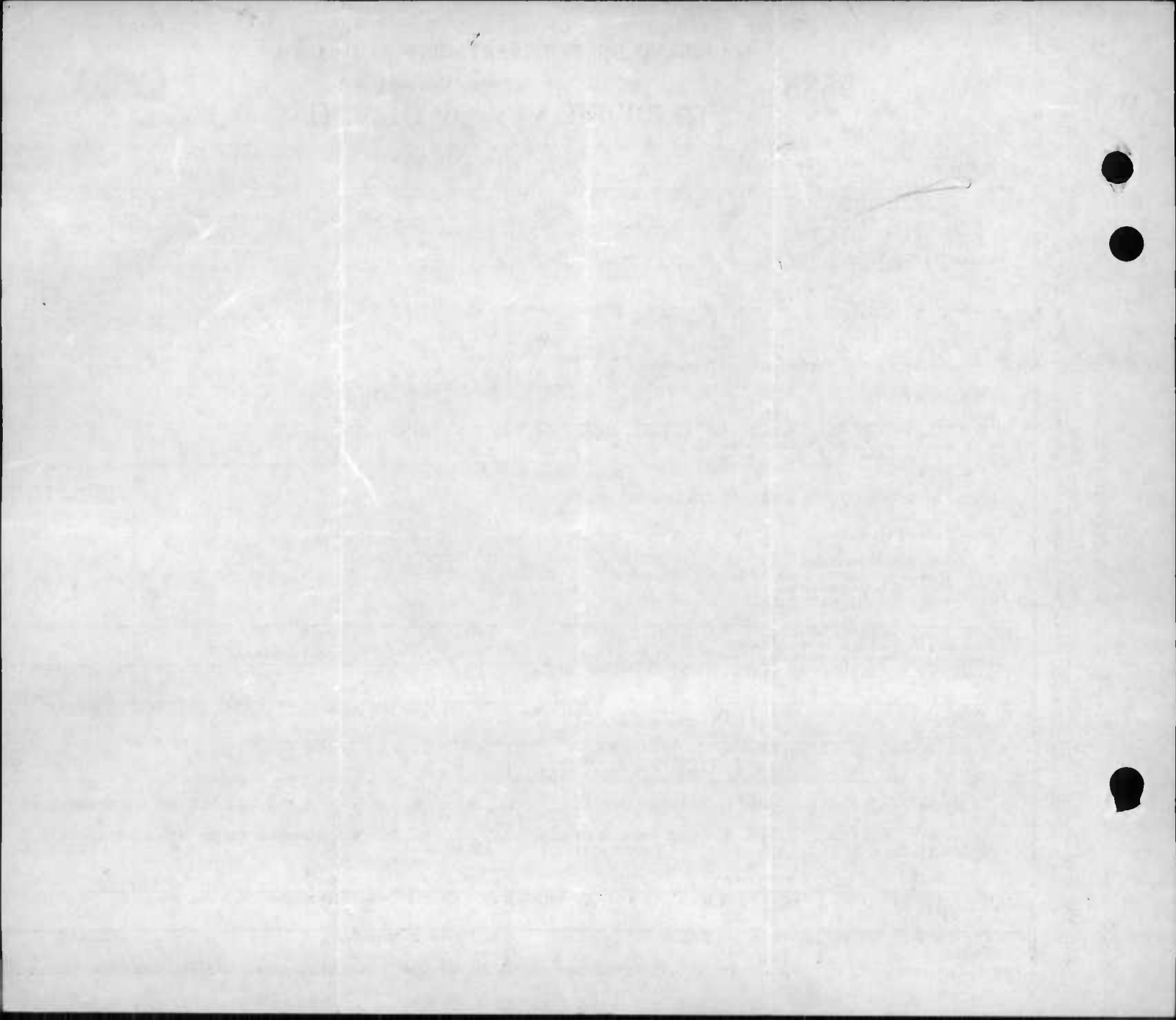
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 8/12, 1954, to 10/9, 1955, that I last saw the deceased

alive on 10/6, 1955, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Oct 12 55</u>	<u>Belwood Ave</u>	<u>Balto</u>	<u>7 - Ind</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>10-11-55</u>	<u>Cl. W.</u>	<u>Paul L. Chamberlain</u>	<u>6067 Hayford Rd</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09535

Item 14, Film 189 11-16-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>—</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PIKESVILLE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	<u>3V01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Old Courthouse Road</u>		STREET ADDRESS (If rural give location) <u>3563 FAIRFIELD Rd.</u>	<u>✓</u>
3. NAME OF DECEASED: (First) <u>Philip</u> (Middle) <u>ALVIN</u> (Last) <u>RUPPEL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10-25-1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-4-1903</u>
9. AGE last birthday <u>52</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Tavern Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Tavern</u>	11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <u>FRED RUPPEL</u>	
14. MOTHER'S MAIDEN NAME: <u>Elizabeth Fiddler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>52-055-2783</u>		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>		<u>1 month.</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertension</u>		<u>1 yr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	---

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan. 19th, 1955, to Oct. 25th, 1955, that I last saw the deceased alive on Oct. 25th, 1955, and that death occurred at 9:35 P. M, from the causes and on the date stated above.

SIGNATURE <u>James G. Miller, Jr.</u>	ADDRESS <u>Pikesville, Md.</u>	DATE SIGNED <u>10/26/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>10/28/55</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>
LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	24. FUNERAL DIRECTOR	ADDRESS <u>Frank H. Hurrell, Pikesville, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>10/27/55</u>	REGISTRAR'S SIGNATURE <u>Harold A. Ruff</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 2 1955

RECEIVED

9537

Item 9: funeral director's correction 10-10-55L

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND	CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Towson</u>	STATE <u>MARYLAND</u> COUNTY <u>3401-4</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> OR <u>CITY</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>THE SORESENSEN NURSING HOME 7912 RUXWAY ROAD</u>	STREET ADDRESS (If rural give location) <u>347 ILLCHESTER AVE.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>NATHAN EDWARD RUTLEDGE</u>		<u>OCT. 2 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>FEB. 7, 1862</u>
9. AGE last birthday: <u>92</u> yrs. <u>8</u> Months <u>2</u> Days <u>2</u> Hours <u></u> Min.		10. USUAL OCCUPATION Give kind of work done during most of working life, when retired: <u>WRIGHT</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>WILLIAM RUTLEDGE</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZA SILK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>6804</u>	
17. INFORMANT & ADDRESS: <u>MRS. VERA RITZMAN HIGHVIEW AVE</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>myocardial Hypertrophy with failure</u>		<u>10 years</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Chronic myocarditis.</u>		<u>10 years</u>
(c) <u>General Arteriosclerosis</u>		<u>10 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>umbilical Hernia.</u>		<u>10 years</u>
19a. DATE OF OPERATION: <u>none</u>	19b. MAJOR FINDINGS OF OPERATION: <u>no operation.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>no</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>no</u>	(CITY OR TOWN) <u>no</u> (COUNTY) <u>no</u> (STATE) <u>no</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>no</u>
22. I hereby certify that I attended the deceased from <u>9-14-1955</u> , to <u>10-2-1955</u> , that I last saw the deceased alive on <u>9-27, 1955</u> , and that death occurred at <u>12.30 P.M.</u> from the causes and on the date stated above.		
SIGNATURE (Degree or title) <u>James Graham Martin MD</u>		DATE SIGNED <u>10-4-1955</u>
ADDRESS <u>516 Catherine St</u>		
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>OCT. 5, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>WEST LIBERTY CHURCH CEMETERY (METHODIST)</u>
DATE REC'D BY LOCAL REGISTRAR <u>10-5-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Henry M. Jenkins</u> ADDRESS <u>4905 Park Dr.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

516 Cathedral St

9538

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	LENGTH OF STAY (in this place) <u>28 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Irving Place</u>		STREET ADDRESS (If rural give location) <u>6 Irving Place</u>	

3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
<u>PETER A. SCHEDES</u>			DATE OF DEATH: <u>Oct. 16</u> 1955		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 1st. 1881</u>		9. AGE last birthday <u>74</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>US Army</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Bernard Schmedes</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Gotlben</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>W.W.#1</u>		16. SOCIAL SECURITY No. <u>213-20-8743</u>	17. INFORMANT & ADDRESS: <u>Marie E. Schmedes, Wife, 6 Irving &</u>
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18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>		<u>30 months</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary artery arteriosclerosis</u>		<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis generalized</u>		<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>—</u>	19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Lucien D. Adams ADDRESS Pikesville 8 Md DATE SIGNED 10/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10/16/55</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
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DATE REC'D BY LOCAL REGISTRAR <u>October 17, 1955</u>	REGISTRAR'S SIGNATURE <u>Dorothy G. Newell</u>	24. FUNERAL DIRECTOR ADDRESS <u>Frank H. Newell - Pikesville 6, Md.</u>
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MARGIN RESERVED FOR BINDING

BUREAU V. S.

OCT 24 1955

RECEIVED

09538

MARYLAND

9539

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3015 Woodside Avenue		STREET ADDRESS (If rural, give location) 3015 Woodside Avenue	
3. NAME OF DECEASED (First) Mrs. Bertha (Middle) May (Last) Schrufer		4. DATE OF DEATH (Month) Oct. (Day) 2nd (Year) 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 4/1/1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at Home	9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Crosby		14. MOTHER'S MAIDEN NAME Emma Schauermann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Louis Schrufer, 3015 Woodside Avenue #11			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X Immediate cause (a) Cerebral Hemorrhage			
Antecedent cause(s) (b) Hypertension & V. Disease			
(c) Arteriosclerosis			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 8, 1950, to Oct. 2, 1955, that I last saw the deceased alive on 10/1, 1955, and that death occurred at 11:50 P. m., from the causes and on the date stated above.			
SIGNATURE Nathan Janney MD		ADDRESS 7101 Harford Rd. Balto. DATE SIGNED 10/3/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 10/5/1955	NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	LOCATION (City, town, or county) Baltimore, Maryland (State)
DATE REC'D BY LOCAL REG. 10/5/55	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14	ADDRESS

MARGIN RESERVED FOR BINDING

Dr. Janney
7101 Harford Road
9 and 10

Please call us when Ready HA 6 1460

9540

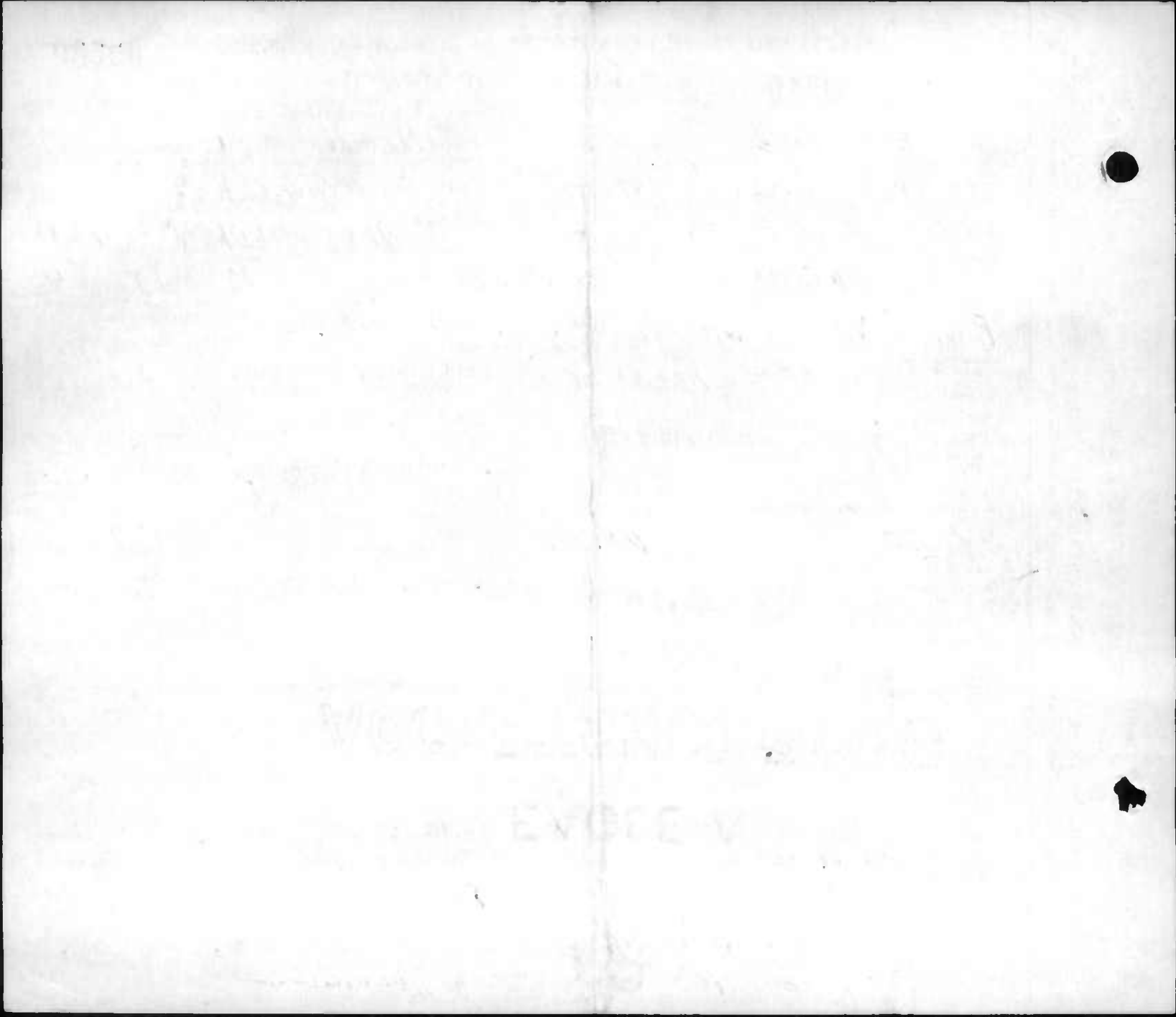
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO</u>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>RURAL - VILLANOVA</u>		LENGTH OF STAY (in this place) <u>4 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4105 ESSEX Rd.</u>		NURSING HOME <u>KATHERINE ROBB</u>		STREET ADDRESS (If rural give location) <u>922 WILLOWOOD PARKWAY</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>VIRGINIA</u>		(Middle)		(Last) <u>SEVIER</u>		DATE OF DEATH: <u>10</u> <u>17</u> 19 <u>53</u>	
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH: <u>Unk. Abt. 1866</u>	
9. AGE last birthday <u>Abt. 89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Robert O. Elliott</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Bean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>C. Maurice Weidmeyer, Annapolis, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>UREMIA</u>						<u>7 days</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertension C.V. RENAL DISEASE - Antecedent</u>						<u>8 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>52</u> to <u>OCT. 17</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>OCT. 17, 1953</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Purpura</u>		ADDRESS <u>8204 LIBERTY RD BALTO. 7, MD.</u>		DATE SIGNED <u>10/17/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town or county) (State) <u>Baltimore, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-27</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>4510 Liberty Hghts. Avenue</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



09540

MARYLAND

9541

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Whitmarsh</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Whitmarsh</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RED LION ROAD Box 1009</u>		STREET ADDRESS (If rural, give location) <u>Red Lion Road Box 1009</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>GREEN</u>	(Last) <u>Sheppard</u>
4. DATE OF DEATH	(Month) <u>Oct.</u>	(Day) <u>27</u>	(Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, <u>WIDOWED, DIVORCED,</u> (Specify)	8. DATE OF BIRTH <u>Nov. 27, 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	9. AGE last birthday <u>93</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN Sheppard</u>		14. MOTHER'S MAIDEN NAME <u>Martha - UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Flora Edna Dolan Bel Air Md</u>		<u>Route 3 Box 44</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause		(a) <u>Coronary Thrombosis</u>		<u>Sudden</u>	
Antecedent cause(s)		(b) <u>Bronchial Pneumonia</u>		<u>1 wk</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Arteriosclerotic Cardio-Vascular disease</u>		<u>2 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 1</u> , 19 <u>55</u> , to <u>Oct 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>William Gardner M.D.</u>		ADDRESS <u>Balto 6</u>		DATE SIGNED <u>10/27/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>Oct 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	
LOCATION (City, town, or county) (State) <u>Fountain Green Md</u>		24. FUNERAL DIRECTOR <u>Joseph J. [unclear] Bel Air Md</u>		ADDRESS	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

State Dept of Health
2411 N Charles St

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09541

9542

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>Whitemarsh</u>		<u>20 Years</u>		<u>Whitemarsh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>1017 Red Lion Road</u>				<u>1017 Red Lion Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Harry F. Simpson</u>				<u>10-25-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Aug. 21, 1886</u>	<u>69 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Watchman-Retired</u>		<u>Distillery</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard Simpson</u>				<u>Sarah McMahon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>212-01-4880A</u>		<u>Frieda R. Simpson-1017 Red Lion Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardiovascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>6 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>7-00</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>July 14</u> , 19 <u>40</u> , to <u>Oct 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>55</u> , and that death occurred at <u>3:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James J. White M.D.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>10-29-55</u>		<u>St. Michael's</u>		<u>Perry Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>ACT 31 1955</u>		<u>Dr. Walter Hammett</u>		<u>Sarah's Funeral Home - 7401 Belair Rd</u>			

EMOLUMENTS

THE FOLLOWING IS A LIST OF THE EMOLUMENTS RECEIVED BY THE OFFICERS AND MEMBERS OF THE BOARD OF HEALTH, DURING THE YEAR 1955. THE AMOUNTS ARE IN DOLLARS AND CENTS.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

10-34

DEPT. OF HEALTH

1. NAME OF DECEASED (PRINT OR TYPE)

2. DATE OF DEATH (MONTH, DAY, YEAR)

3. PLACE OF DEATH (STREET, CITY, STATE, ZIP)

4. TIME OF DEATH (HOUR, MINUTE)

5. CAUSE OF DEATH (DISEASE, INJURY, ETC.)

6. MANNER OF DEATH (NATURAL, ACCIDENT, SUICIDE, ETC.)

7. SIGNATURE OF PHYSICIAN (PRINT NAME, SIGNATURE)

8. SIGNATURE OF REGISTRAR (PRINT NAME, SIGNATURE)

9. SIGNATURE OF WITNESS (PRINT NAME, SIGNATURE)

10. SIGNATURE OF DECEASED (PRINT NAME, SIGNATURE)

11. SIGNATURE OF NEXT OF KIN (PRINT NAME, SIGNATURE)

12. SIGNATURE OF BURIAL SOCIETY (PRINT NAME, SIGNATURE)

13. SIGNATURE OF FUNERAL HOME (PRINT NAME, SIGNATURE)

14. SIGNATURE OF CEMETERY (PRINT NAME, SIGNATURE)

15. SIGNATURE OF CHURCH (PRINT NAME, SIGNATURE)

16. SIGNATURE OF MINISTERS (PRINT NAME, SIGNATURE)

17. SIGNATURE OF MUSICIANS (PRINT NAME, SIGNATURE)

18. SIGNATURE OF FLORISTS (PRINT NAME, SIGNATURE)

19. SIGNATURE OF CATERERS (PRINT NAME, SIGNATURE)

20. SIGNATURE OF OTHERS (PRINT NAME, SIGNATURE)

BUREAU W. S.S.

OCT 1955

RECEIVED

9543

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Owings Mills		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 2919 E. Federal Street 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood Training School				STREET ADDRESS (If rural give location) Baltimore, Maryland ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) Michael Joseph Sinclair				4. DATE (Month) (Day) (Year) OF DEATH: 10 19 55			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 6/14/55	9. AGE last birthday: 4 yrs.	IF UNDER 1 YEAR: 4 Months	IF UNDER 24 HRS.: 3 Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --			10B. KIND OF BUSINESS OR INDUSTRY: --	11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Ferdinand Sinclair				14. MOTHER'S MAIDEN NAME: Helen Constance Mallon			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unk.) (If Yes, give war or dates of service) --			16. SOCIAL SECURITY NO. --	17. INFORMANT & ADDRESS: Rosewood Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pneumonia, Bilateral						2 days	
ANTECEDENT CAUSE (B) Acute Bronchitis						3 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hydrocephalic, meningocele (Arnold Chiari Syndrome)						birth	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/17 , 19 55 to 10/19 , 19 55 that I last saw the deceased alive on 10/19 , 19 55 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
SIGNATURE Harry B. Butler M.D.		ADDRESS Owings Mills, Md		DATE SIGNED 19 Oct. '55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10-20-55		Baltimore National		Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR Oct. 21, 1955		REGISTRAR'S SIGNATURE Mary Elise		24. FUNERAL DIRECTOR Walter Burke / Bradley, Henslock, 94		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 24 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 9,22 FilmG188 11-4-55 et

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CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>3 days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>1036 W. Saratoga St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>FRANK A. SMITH</u>				<u>October 21 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>7-10-96</u>	
9. AGE last birthday <u>(59) 50</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-14-5076</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>ASPHYXIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>ASPIRATION OF BLOOD</u>						<u>SUDDEN</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HEMORRHAGE FROM LUNG ABSCESS RIGHT LOWER LOBE</u>						<u>UNKNOWN</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <u>VA</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 18, 19 55</u> , to <u>October 21, 19 55</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VanderGriff</u>				ADDRESS (Street, city, town, state) <u>Baltimore, Md</u>			
DATE <u>Oct. 28, 1955</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie Williams</u>		ADDRESS <u>322 N. Schroeder St. Balto. Md</u>	

CERTIFICATE OF DEATH

Form 10-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

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RECEIVED

1. NAME OF DECEASED
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3. AGE
4. OCCUPATION
5. PLACE OF BIRTH
6. DATE OF DEATH
7. TIME OF DEATH
8. PLACE OF DEATH
9. CAUSE OF DEATH
10. MANNER OF DEATH
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09545

9545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Fort Howard</u>		<u>31 days</u>		OR TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1921 N. Payson Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>HENRY</u>		(Middle) <u>(NMI)</u>		(Last) <u>SMITH</u>		<u>October 22 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-23-89</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joe Smith</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>CARCINOMA OF TAIL OF PANCREAS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>10-7-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Exploratory laparotomy</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>VA</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 21, 1955</u> , to <u>October 22, 1955</u> , that he came to the deceased's residence on <u>October 22, 1955</u> , and that death occurred at <u>3:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegriff</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, Ft. Howard, Md</u>		DATE SIGNED <u>10/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Oct. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Lawson L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs Edward Ringold</u>		ADDRESS <u>Mrs Edward Ringold Funeral Home 1463 N. Carey St., Balto. Md.</u>	

NOTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE BUREAU OF VITAL STATISTICS, STATE OF MARYLAND, BY THE PERSON OR PERSONS NAMED HEREIN.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Page One

1. Usual Residence of Deceased

Baltimore

Married

White

Age

31

Sex

John A. Brown

John A. Brown

John A. Brown

Color

White

Married

White

White

Age

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BUREAU V. S.

OCT 23 1933

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09546

9546

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH <i>Balto.</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>MARYLAND</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <i>BALTIMORE-CAT.</i>		1 day		TOWN <i>BALTIMORE</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <i>Rienhard Nursing Home.</i>				306 Ingleside Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>KATHERINE</i> (Middle) <i>S.</i> (Last) <i>SMITH</i>				(Month) <i>Oct.</i> (Day) <i>27</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>FEMALE</i>	<i>WHITE</i>	<i>SINGLE</i>	<i>11-27-1892</i>	<i>62</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>BOOKKEEPER</i>		<i>STEEL MILLS</i>		<i>BALTIMORE MD.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>THOMAS B. SMITH</i>				<i>SALLIE E. ENGLAR</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>NO</i>		<i>278-07-1529A</i>		<i>MRS. JOHN A. MASON 306 Ingleside Ave. (28)</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <i>Left ventricular failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i>			
DUE TO ANTECEDENT CAUSE(S) (B) <i>ASCVD</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Marked obesity</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JUNE 6</i> , 19 <i>55</i> , to <i>OCT 27</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>OCT 26</i> , 19 <i>55</i> , and that death occurred at <i>4A</i> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<i>Stephen Lee Nagness</i>				<i>M.D. 908 Frederick Rd, Catonsville, Md. 10-27-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>10/29/55</i>		<i>LODON PARK</i>		<i>BALTO. MD.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>31-1955</i>		<i>Victor E. Harry</i>		<i>G. Truman Schuch</i>		<i>3512 Fred. (29) Ave.</i>	
DATE							

BUREAU V. S.

OCT 31 1975

MARYLAND STATE DEPARTMENT OF HEALTH

09547

2411 N. Charles Street, Baltimore

9547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> <u>08X2</u>	
TOWN <u>CATONSVILLE</u>		TOWN <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 FOSTING AVENUE</u>		STREET ADDRESS (If rural give location) <u>Waldorf, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>BENJAMIN</u>		(Last) <u>SNEJIL</u>	
4. DATE OF DEATH <u>OCT.</u>		(Month) <u>16</u> (Day) <u>1955</u> (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 10, 1883</u>
9. AGE last birthday <u>72</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Snejil</u>		14. MOTHER'S MAIDEN NAME <u>Devora ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Esther Rosenstein</u>		<u>Waldorf, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X
Immediate cause(a) Arterio Sclerotic Cardio Vascular Dis.

INTERVAL BETWEEN ONSET AND DEATH

5 yrs.

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Biliary Cirrhosis

6 months.

(c) Diabetes Mellitus

1 yr.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct., 1953, to Oct. 16, 1955, that I last saw the deceasedalive on Oct. 16, 1955, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

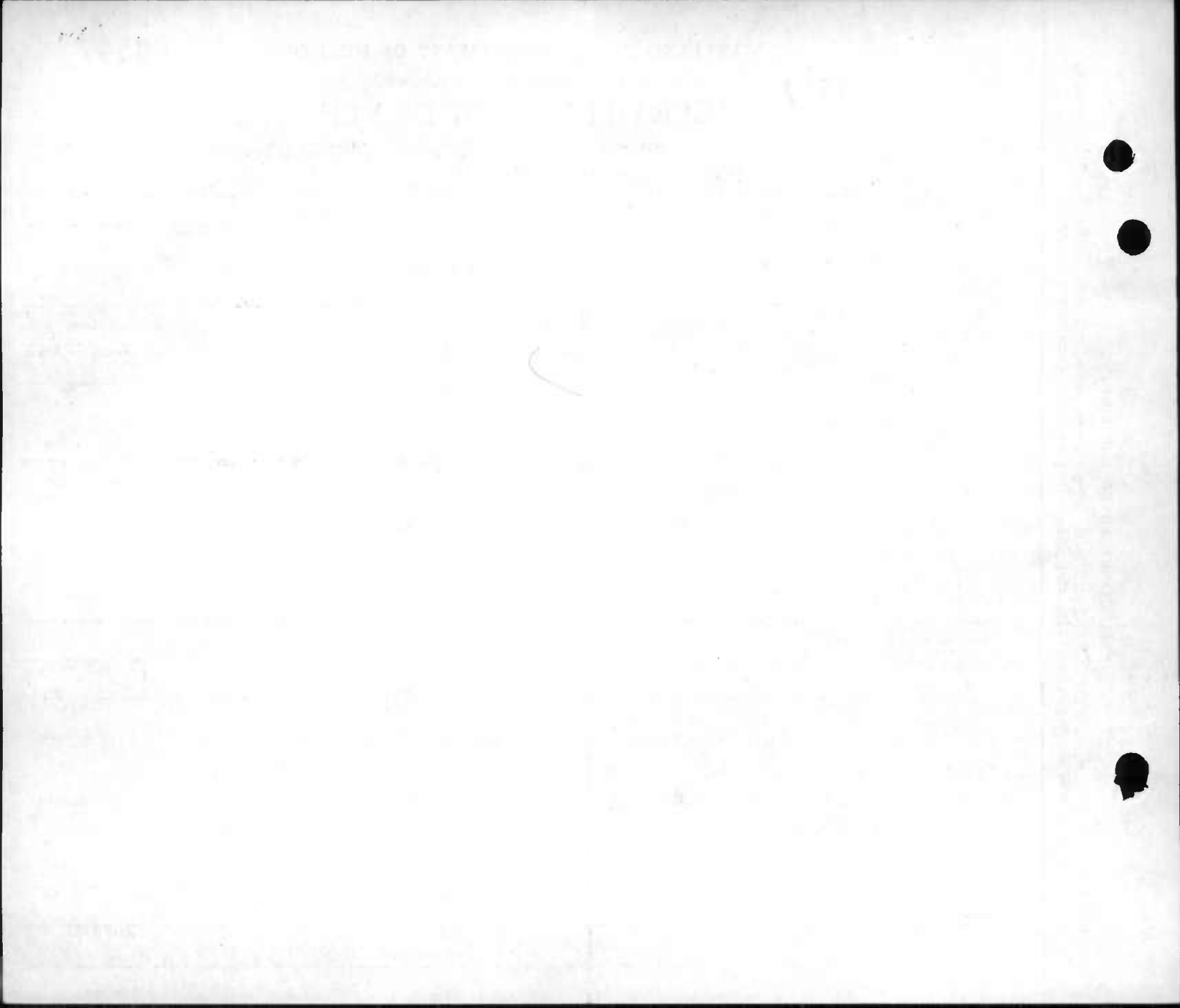
ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Oct 18/55</u>	NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	LOCATION (City, town, or county) <u>Baltimore Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>10-27</u>	REGISTRAR'S SIGNATURE <u>Dr. W. Hedra</u>	24. FUNERAL DIRECTOR <u>Vol. Levinson & Bros. Inc.</u>	ADDRESS <u>1124-26 N. North Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09548
 9548 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>X</u> TOWN <u>Baltimore</u>	<u>10 years</u>	<u>Baltimore</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>00 8812 Old Harford Rd.</u>		<u>8812 Old Harford Rd.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Laura</u>	(Middle) <u>Snidemiller</u>	OF DEATH: <u>October 1 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>May 19, 1875</u>
9. AGE last birthday: <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country):	11. CITIZEN OF WHAT COUNTRY?
<u>Retired Housewife</u>		<u>West Virginia</u>	<u>USA</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Charles Barker</u>		<u>Emily Place</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>NONE</u>	
17. INFORMANT & ADDRESS:			
<u>Austin E. Richards - 8812 Old Harford Rd.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
159X IMMEDIATE CAUSE (A) <u>Co of large intestine</u>			
ANTECEDENT CAUSE (S): DUE TO (B) <u>arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12 Feb, 1955</u> , to <u>1 Oct, 1955</u> , that I last saw the deceased alive on <u>30 Sept. 1955</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Samuel L. Luper</u>		M. D. <u>200 E. Cold Spring Lane</u> DATE SIGNED <u>1 Oct 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>10-4-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>HUNTINGTON Cem.</u>		<u>West Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>October 1st 1955</u>		<u>Wm Cross Jones - 1227 St Paul St</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9549
Items 18-22 from Gies 11-10-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09551

Reg. Dist.

No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Owings Mills</u>		<u>33 yrs.</u>		TOWN <u>Baltimore</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Training School</u>				STREET ADDRESS (If rural, give location) <u>109 S. Ann Street</u>			
3. NAME OF DECEASED:			(First) (Middle) (Last)		4. DATE OF DEATH		
(Type or Print) <u>Adam</u>			<u>Sobus</u>		<u>10 24 19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>single</u>	<u>7/31/09</u>	<u>46</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		
					<u>Maryland</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Michael Sobus</u>				<u>Anna Szafarz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<u>Anna Sobus 15 S.Castle Street</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>578x</u> Immediate cause (a) <u>Peritonitis due to perforation of ulcer in terminal ileum</u>							
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u> stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		<u>Paul F. Gierm</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
				M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		<u>10/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/27/55</u>		<u>St. Stanislaus Cemetery</u>		<u>1300 Dundalk Ave-Balto, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-26-55</u>		<u>A. W. Hedrick</u>		<u>George G. Weber</u>		<u>705 S. Ann St.</u>	

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THE UNIVERSITY OF CHICAGO
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MARYLAND STATE DEPARTMENT OF HEALTH

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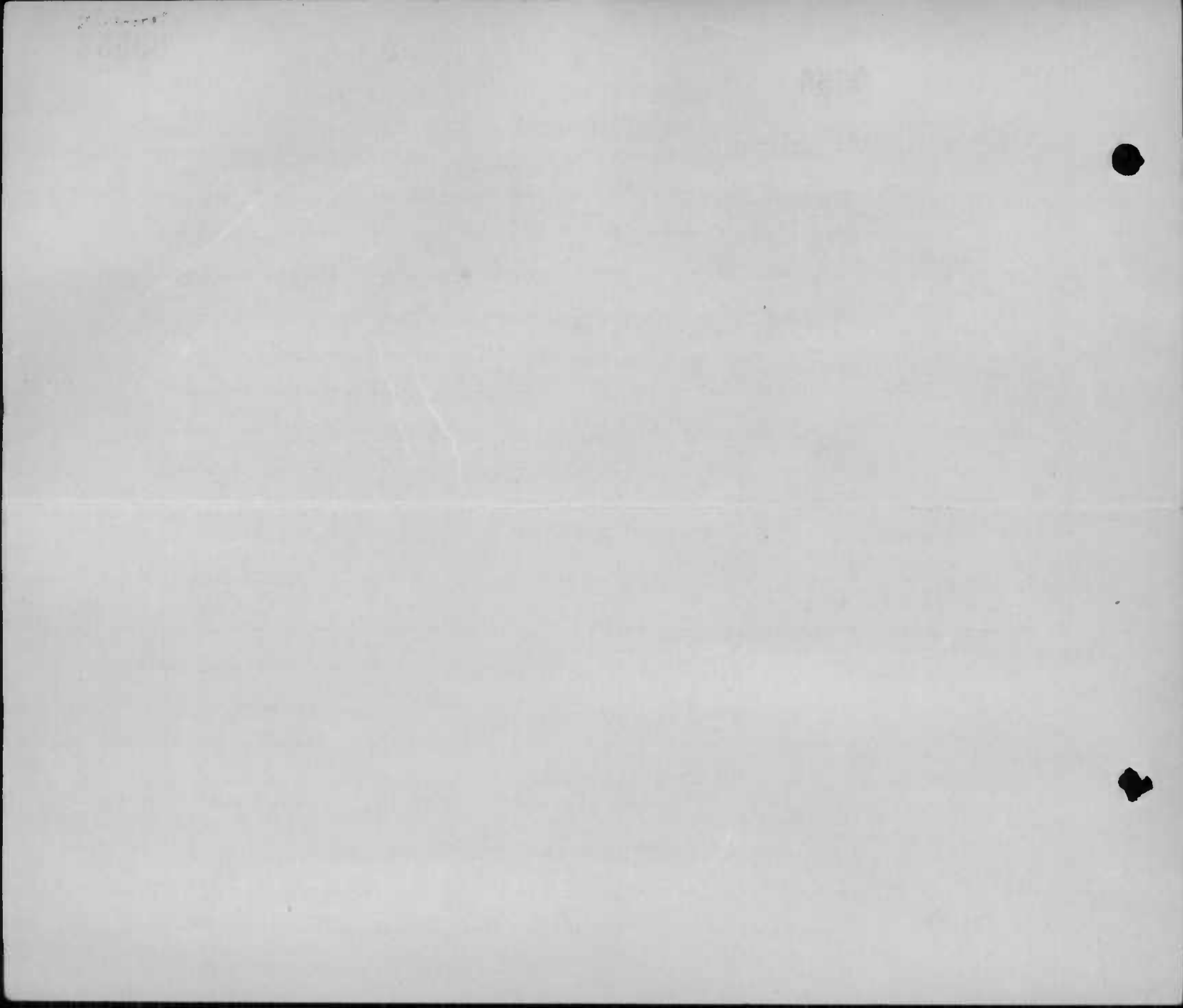
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 38

Item 12 Film G187 10-14-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>3401-4</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore County Court House</u>		STREET ADDRESS (If rural, give location) <u>850 Hillman Court</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>John A. Soderlund</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 7 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov 4-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WATCHMAN</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>215-01-1712</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Stella M. Soderlund-</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Charles F. O'Donnell MD</u>		DATE SIGNED <u>10/7/55</u>	
(Degree or title)		ADDRESS <u>7501 York Rd Towson Md</u>	
23. BURIAL, CREMATION OR DISPOSAL (Specify) <u>Burial</u>	DATE THEREOF <u>10/10/55</u>	NAME OF CEMETERY OR CREMATORY <u>BALTO Gen.</u>	LOCATION (City, town, or county) (State) <u>BALTO Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>✓</u>	24. FUNERAL DIRECTOR <u>Leonard Luck</u>	ADDRESS <u>3305 Nayford</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **09549**
9551 **CERTIFICATE OF DEATH** Reg. Dist. No. **31**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Randallstown		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randallstown X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Briarstone Rd.				STREET (If rural give location) ADDRESS Briarstone Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last) Henry Thomas Sorrell				4. DATE (Month) (Day) (Year) OF DEATH: Oct. 30 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: Aug. 26, 1864	9. AGE last birthday 91 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor and Builder			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Sorrell				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mary Viola Smith - Briarstone Rd.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 442X							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) Chronic nephritis - c. chemia -						3 MOS	
(B) Hypertensive C.V. disease -							
(C) Renal insufficiency -						5 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from APRIL 1, 1951 , to OCT 27, 1955 , that I last saw the deceased alive on OCT 27, 1955 , and that death occurred at 11:30 M. from the causes and on the date stated above.							
SIGNATURE Thomas E. Wheeler		ADDRESS M. D. 3601 Clarendon Rd - Balt 7 -		DATE SIGNED 11-1-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 2, 1955		NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 11/1/55		REGISTRAR'S SIGNATURE U. W. Helrich		24. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Hgts. Ave.	

CONFIDENTIAL
EXCLUDED
FROM
PUBLIC RELEASE
DATE 01-01-00

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

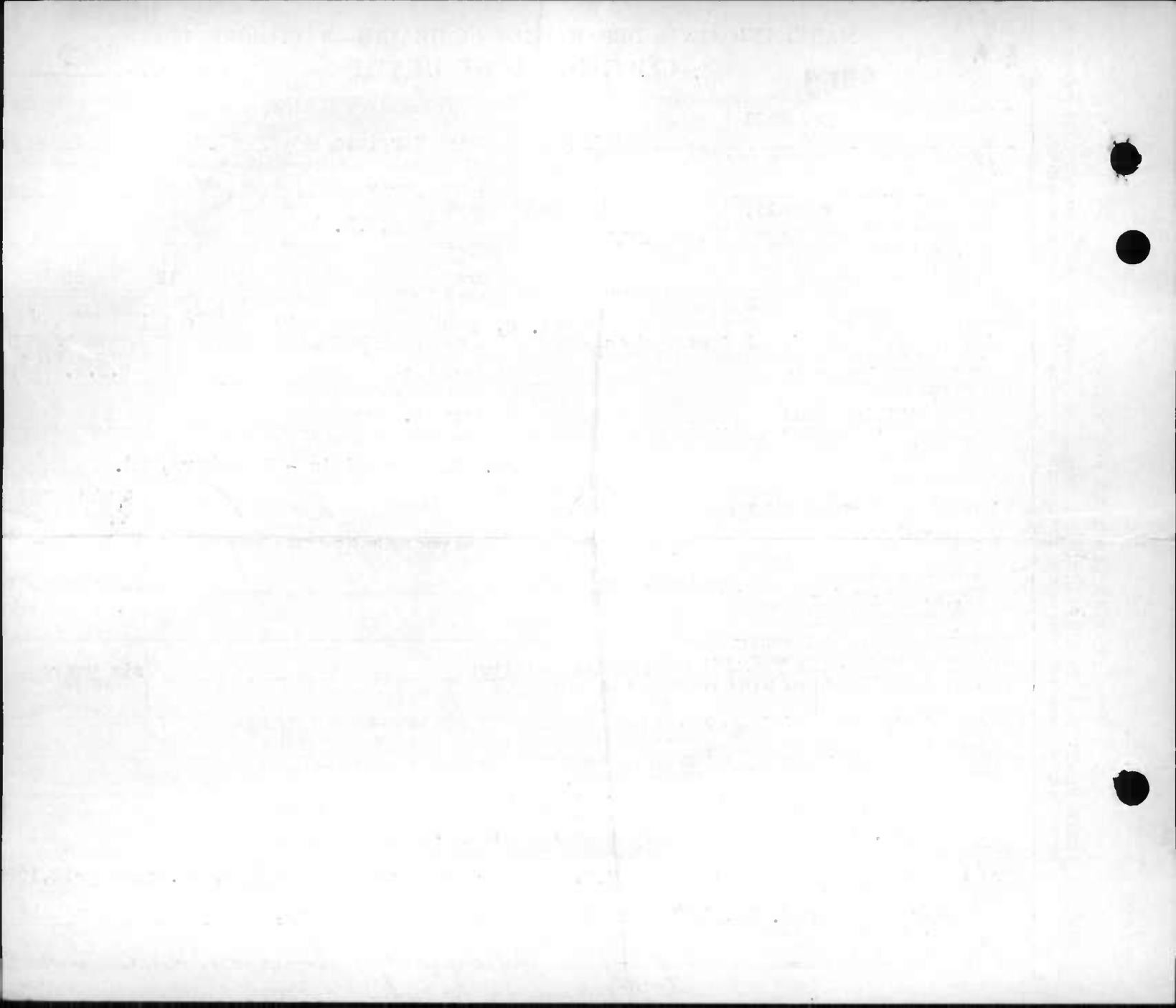
CERTIFICATE OF DEATH

Reg. Dist. No.

9552

09553

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ivy Hall</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ivy Hall, 19 Harrison Street Baltimore 20, Maryland</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY <u>Page</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Luray</u> STREET ADDRESS (If rural, give location) <u>R.F.D. 4</u>			
3. NAME OF DECEASED: (Type or Print) <u>Lorah</u>		(First) (Middle) (Last) <u>Sours</u>		4. DATE OF DEATH: <u>10</u> (Month) <u>12</u> (Day) <u>19</u> (Year) <u>55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 8, 1886</u>	9. AGE last birthday: <u>69</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>4</u> Hours <u>4</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>			
13. FATHER'S NAME: <u>William Judd</u>			14. MOTHER'S MAIDEN NAME: <u>Mary A. Judd</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Clifford Ellis - Raspeburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>153X</u> Immediate cause (a) <u>Secondary (metastatic) carcinoma of liver</u> DUE TO Antecedent cause(s) (b) <u>Carcinoma of colon</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>(260X)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>four weeks ?</u> <u>four weeks ?</u>			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u>				<u>six years</u>			
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2</u> , 19 <u>55</u> ., to <u>October 12</u> , 19 <u>55</u> ., that I last saw the deceased alive on <u>Oct. 11</u> , 19 <u>55</u> , and that death occurred at <u>5:50 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harvey L. Fuller</u>		(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>Ridge Road Baltimore 6, Md.</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>			
LOCATION (City, town, or county) <u>Luray,</u>		(State) <u>Virginia</u>		24. FUNERAL DIRECTOR ADDRESS <u>Bradley Funeral Home Luray, Va.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

9395

2411 N. Charles Street, Baltimore

09554

CERTIFICATE OF DEATH

Reg. Dist. No. 42

Item 9, Film G187 10-19-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rebutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rebutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5100 Rebutus Ave.</u>		STREET ADDRESS (If rural give location) <u>5100 Rebutus Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE E. SPALT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 11 - 55</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 18, 1909</u>	9. AGE last birthday <u>46</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	13. FATHER'S NAME <u>John Spalt</u>		
14. MOTHER'S MAIDEN NAME <u>Laura Bond</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY No. <u>26-12-3795-A</u>		17. INFORMANT <u>Bessie S. Spalt - 5100 Rebutus Ave.</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1 MYOCARDIAL INFARCTION</u>	<u>5 hrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
<u>GENERALIZED ARTERIOSCLEROSIS</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

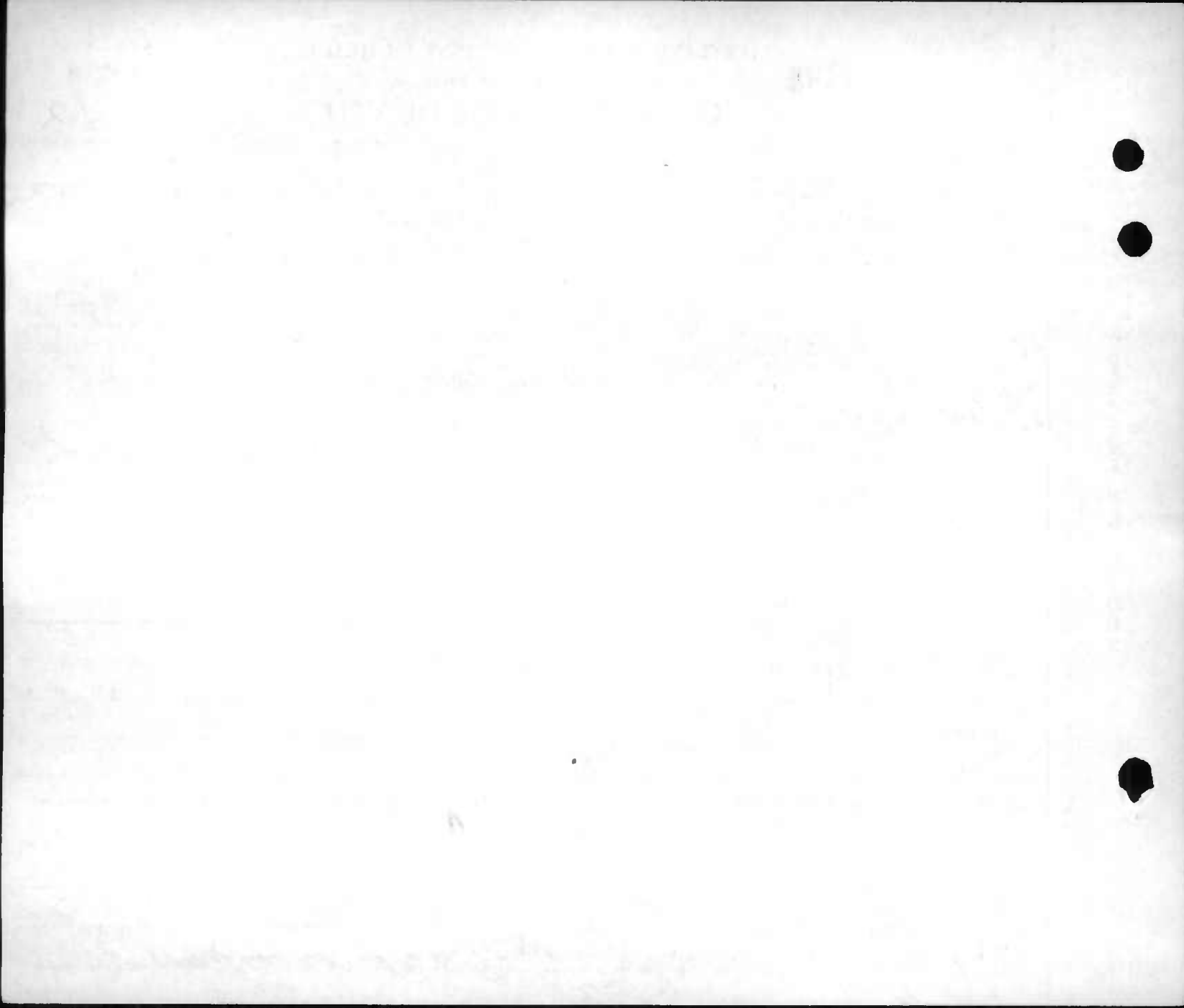
22. I hereby certify that I attended the deceased from 11 Oct, 1955, to 11 Oct, 1955, that I last saw the deceased alive on 11 Oct, 1955, and that death occurred at 6 20 A m., from the causes and on the date stated above.

SIGNATURE George E. Grabeau (Degree or title) MO ADDRESS Elbridge 27, Md DATE SIGNED 12 Oct 55

23. BURIAL/CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 14: 55</u>	<u>Landon Park Cem.</u>	<u>Baltimore - Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FEDERAL DIRECTOR	ADDRESS
<u>10/13/55</u>	<u>A. W. Hedrick</u>	<u>W. H. Kippert</u>	<u>1300 Gaither Place</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

09555

2411 N. Charles Street, Baltimore

9553

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd</u>		STREET ADDRESS <u>Glenarm Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Rodriguez Speiser</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 2, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Speiser</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Hopfer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Villa Maria, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion sudden

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 1, 1950, to Oct. 14, 1955, that I last saw the deceasedalive on Oct. 13, 1955, and that death occurred at 12:55 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

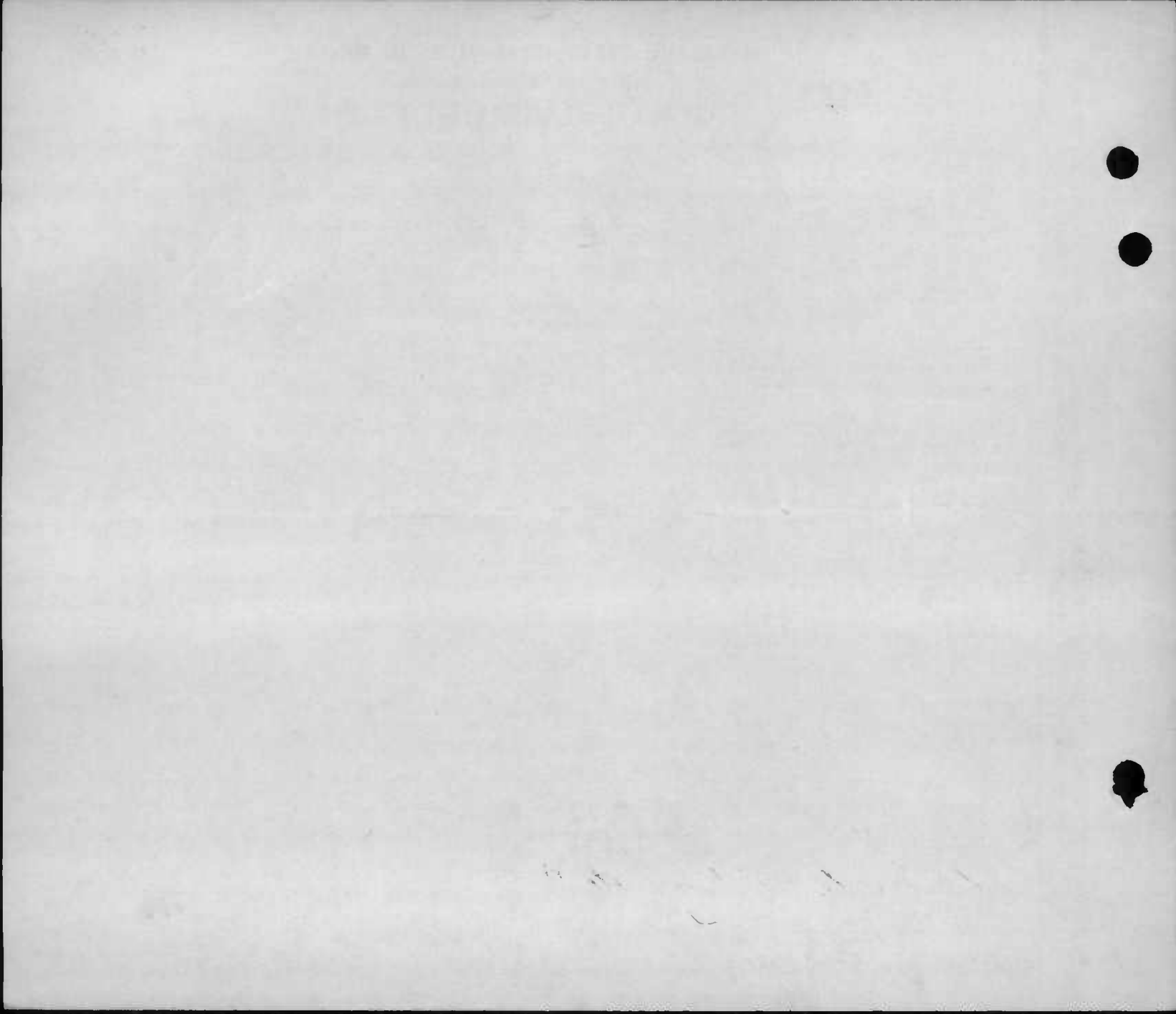
DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>10-17-55</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD.</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>October 15 1955</u>	<u>R.W.</u>	<u>Charles S. Zeller</u>	<u>901 S. CONKLINE ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9554

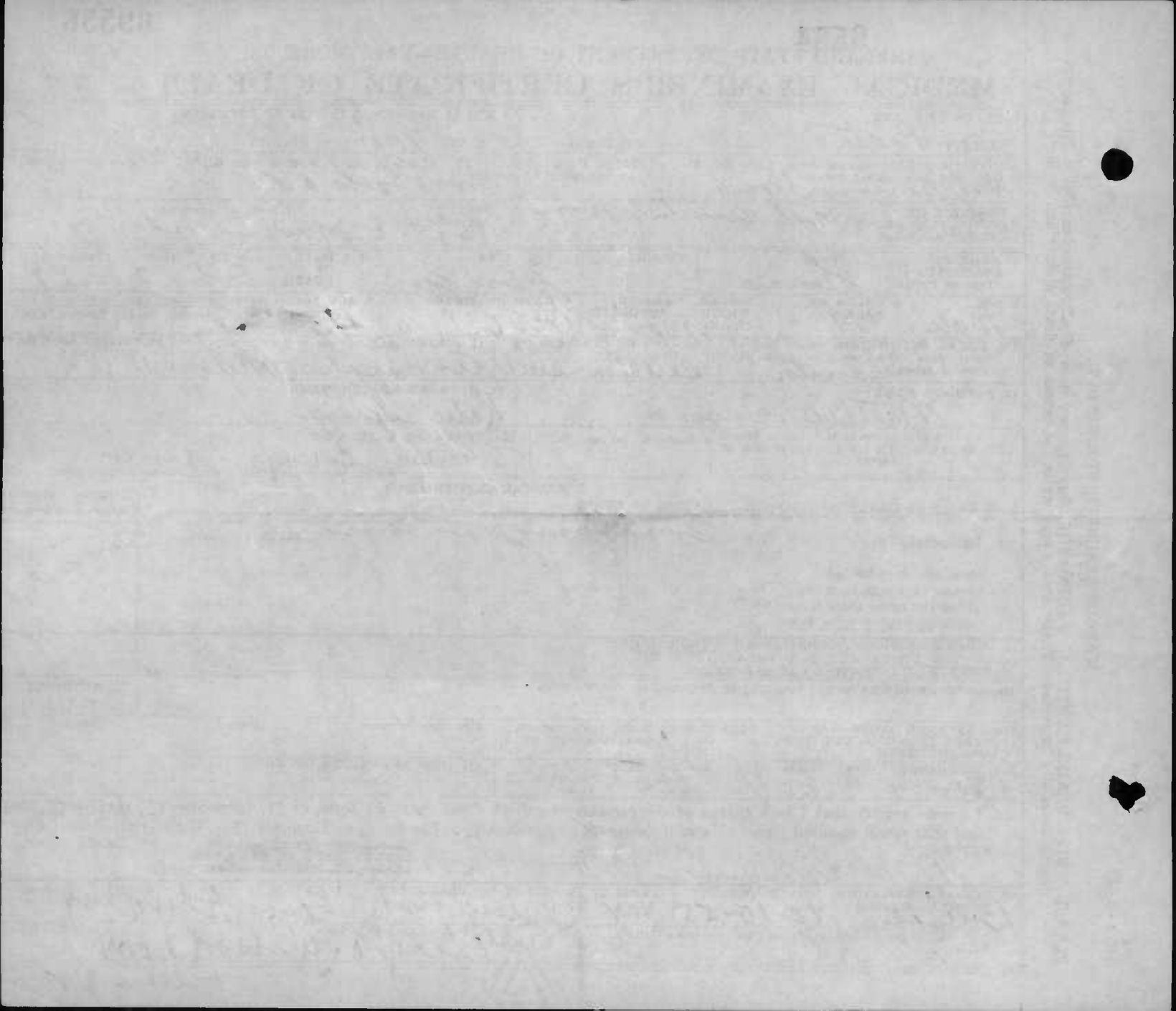
09556

Reg. Dist. 44

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harrison Point</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Balto #5</u>			
HOSPITAL OR INSTITUTION <u>In Mill assembly room</u>		STREET ADDRESS		(If rural, give location) <u>1428 E. Madison St.</u>			
3. NAME OF DECEASED: (First) <u>Thomas</u> (Middle) (Last) <u>Spriggs</u>				4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Ch.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Oct 6, 1910</u>	9. AGE last birthday: <u>45</u>		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Belknap Steel</u>		11. BIRTHPLACE (State or foreign country): <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME: <u>Matthew Diggs</u>				14. MOTHER'S MAIDEN NAME: <u>Katie Spriggs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Theresa Spriggs same</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO						<u>Immediate</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF DEATH <u>Oct 7 1955 6 A.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H. M. Barmine M.D.</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-10-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REG. <u>10-10-55</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>Chas. O. Wilson 2004</u>		ADDRESS <u>Orlean St.</u>	



09550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

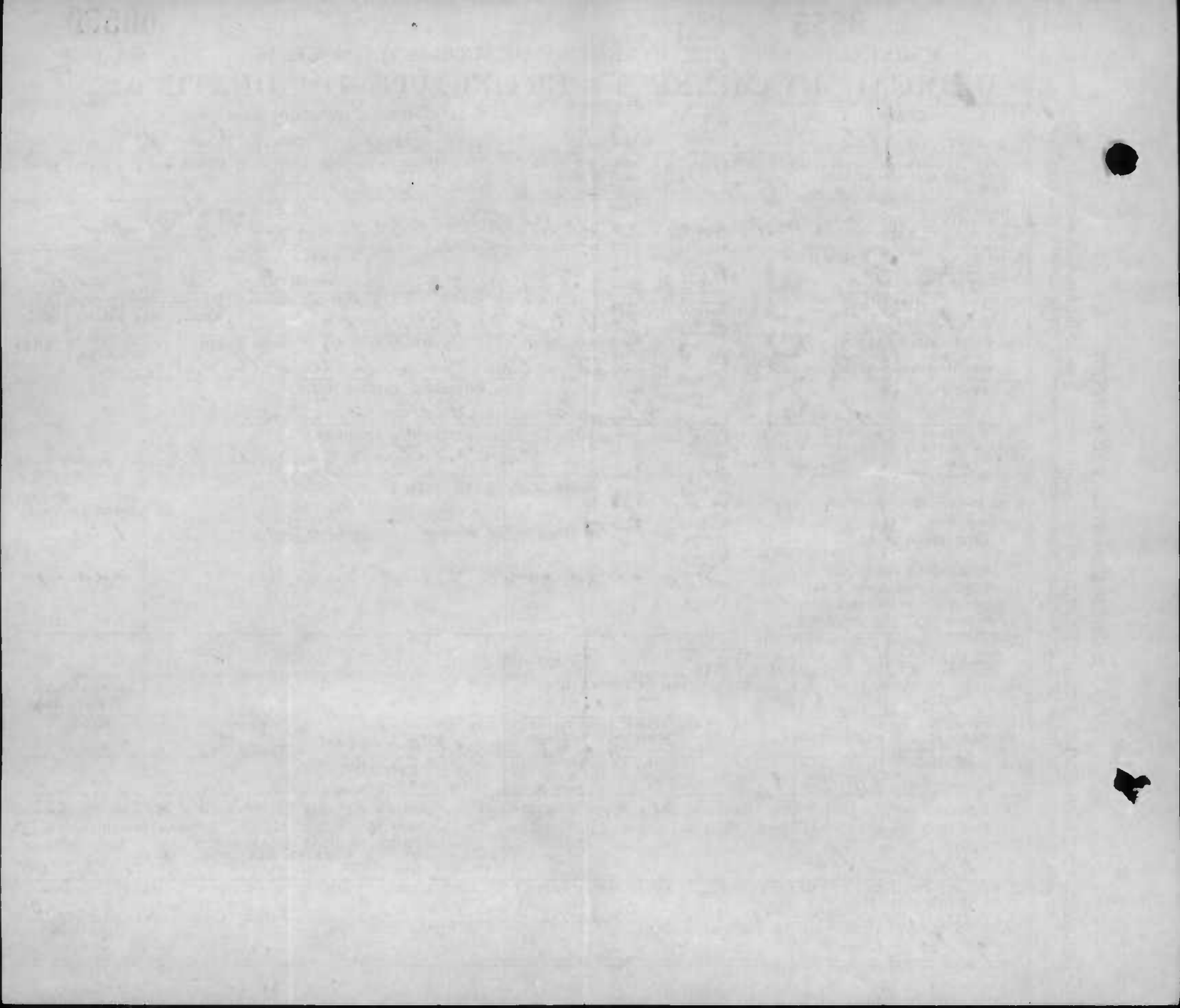
Reg. Dist

No. 2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Balto 7</u>	LENGTH OF STAY (In this place) <u>5 yrs.</u>	CITY (If outside corporate limits write RURAL OR TOWN <u>Balto 7</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6309 Windsor Mill Rd</u>		STREET ADDRESS (If rural, give location) <u>6309 Windsor Mill Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Roy MACK STROUSE</u>		4. DATE OF DEATH <u>Oct 24</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec 19, 1894</u>
9. AGE last birthday: <u>60</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Charlottesville, Va</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Robert S. Sprague</u>		14. MOTHER'S MAIDEN NAME: <u>Georgia Marsh.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT'S ADDRESS: <u>Mrs Martha E. Marble (same address)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>976X Shot thru head c pistol</u> DUE TO		<u>1 hr.</u>	
Antecedent cause(s) (b) <u>Depressed over Court. Summons</u> DUE TO		<u>4 days.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDING OF OPERATION: <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(State) <u>Md.</u>	
21a. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>None</u>	
21c. (City or town) <u>6309 Windsor Mill Rd. Balto.</u>		21d. (State) <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct 24 '55 9:20 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Shot himself.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>D.D. Capha</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-24-'55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		LOCATION (City, town or county) (State) <u>Balto Maryland</u>	
DATE RECD BY LOCAL REG. <u>10/24/55</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	
FUNERAL DIRECTOR <u>Greiswath Burial Co.</u>		ADDRESS <u>4600 Liberty Heights Avenue</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9556

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Parkton</u>		<u>81 yrs.</u>		<u>Parkton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Main St.</u>				<u>Main St.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Pleasant A. Stiffler.</u>				<u>October 17, 1955.</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>August 15, 1874</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>81</u> yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Mail carrier</u>				<u>U.S. Mail</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Parkton, Md.</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Stiffler.</u>				<u>Sarah Baublitz.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>—</u>			
17. INFORMANT & ADDRESS:							
<u>Mrs. Ella Stiffler, Parkton, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>Carcinoma of the Colon</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 1954, to <u>Oct. 17, 1955</u> , that I last saw the deceased alive on <u>Oct. 17, 1955</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>A. M. France</u>				<u>Parkton, Md.</u>		<u>10/19/55</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 20, 1955</u>		<u>Pine Grove Cemetery, Parkton,</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/30/55</u>		<u>Charles J. Tucker</u>		<u>Isaac Hartenstein, New Freedom, Pa.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9557
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09558
 Reg. Dist.

No. 33-

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Locheysville</u>	LENGTH OF STAY (in this place) <u>6 hours</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Freeland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore County Police Station</u>		STREET ADDRESS (If rural, give location) <u>Ruhl Rd.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Walter</u> (Middle) <u>Henry</u> (Last) <u>Stiffler</u>		(Month) <u>Oct.</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>November 8, 1897</u>
9. AGE last birthday: <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country): <u>Bolton, Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Arthur Stiffler</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Ruhl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY No.: <u>204-05-2909</u>	
17. INFORMANT & ADDRESS: <u>Walter Stiffler - Glen Rock, Pa.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Asphyxiation, strangulation by hanging</u>			<u>Sudden</u>
Antecedent cause(s) (b) <u>Chronic alcoholism</u>			
giving rise to the above cause DUE TO			
stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Chronic alcoholism</u>			<u>Unknown</u>
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Rollin C. Hudson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/4/55</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>October 8, 1955</u>	
NAME OF CEMETERY OR CREMATORY: <u>Stiltz Cemetery</u>		LOCATION (City, town, or county) (State): <u>Glen Rock, Pa. R.D.3.</u>	
DATE REC'D BY LOCAL REG: <u>10/8/55</u>		24. FUNERAL DIRECTOR: <u>Jacob Hartenstein, New Freedom, Pa.</u>	

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RECEIVED

1955

1955

1955

BUREAU V. S.

1955

RECEIVED

0558

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Freeland
 TOWN 50yrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore.
 CITY (If outside corporate limits, write RURAL and give nearest town) Freeland.
 OR TOWN 1
 STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED:

(First) Howard (Middle) E. (Last) Sutton.

4. DATE (Month) (Day) (Year) OF DEATH:

October 19, 1955.

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

July 11, 1879

9. AGE last birthday

76 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Farmer

10B. KIND OF BUSINESS OR INDUSTRY:

Own Farm.

11. BIRTHPLACE (State or foreign country):

Balto. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME:

Jefferson Sutton.

14. MOTHER'S MAIDEN NAME:

Sarah Elizabeth Cooper.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS:

Kenneth Sutton, Freeland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A)

DUE TO

(B)

DUE TO

(C)

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

10 yrs.

20 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

None

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

☐

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 1951, to Oct 1955, that I last saw the deceased

alive on 10-6, 1955, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

SIGNATURE

Lucia Schataroff

ADDRESS

New Freedom, Pa.

DATE SIGNED

10/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Oct. 22, 1955

NAME OF CEMETERY OR CREMATORY

Mt. Zion Cemetery

LOCATION (City, town, or county)

Freeland, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

10/20/55

REGISTRAR'S SIGNATURE

Charles J. Sutton

24. FUNERAL DIRECTOR

J. Jacob Hartenstein

ADDRESS

New Freedom, Pa.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09560

9559

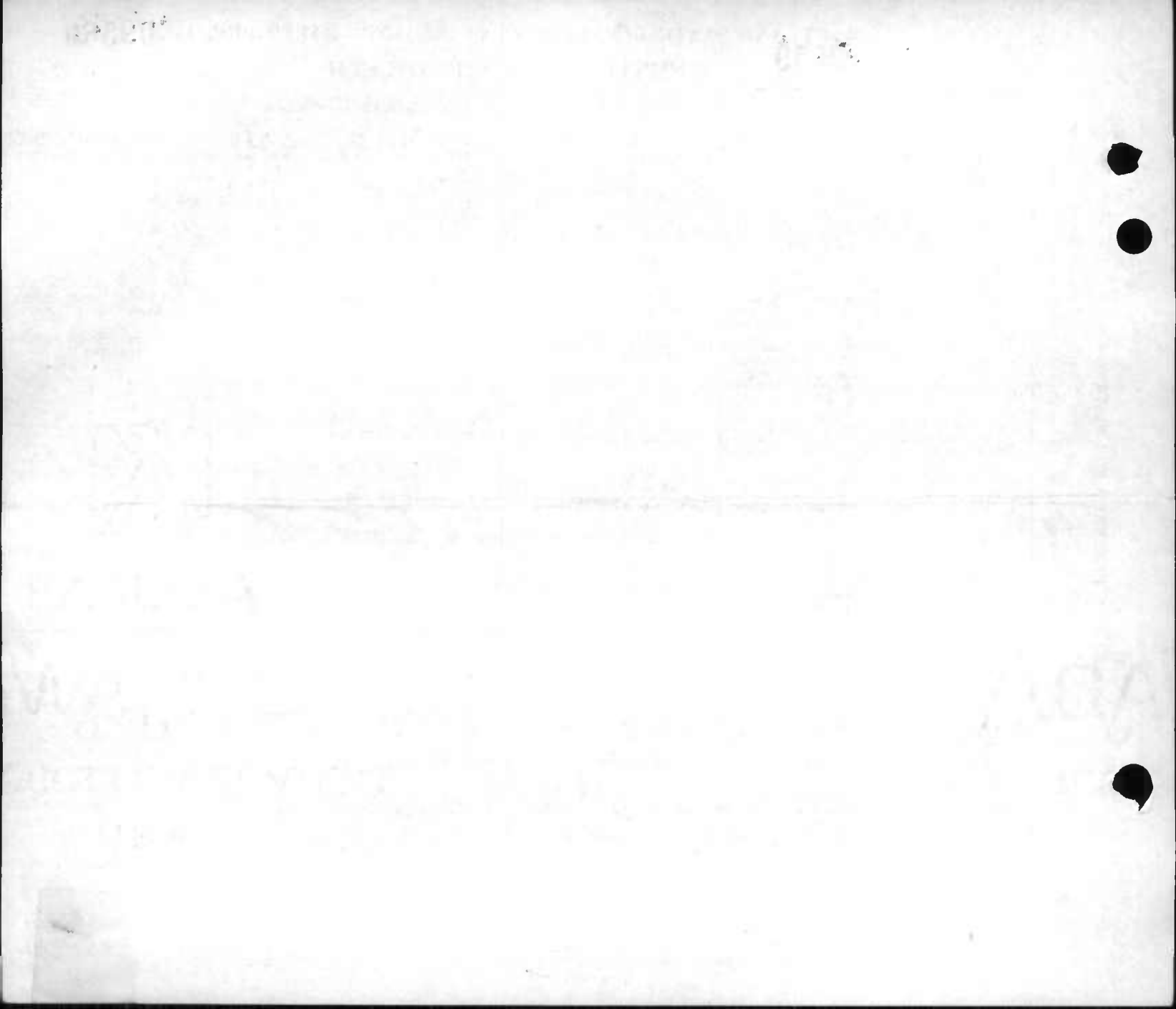
CERTIFICATE OF DEATH

Item 12 Film G188 10-28-55 et

Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u> MARYLAND			STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>LYNCH POINT</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>LYNCH POINT</u>		
LENGTH OF STAY (in this place) <u>50 YRS</u>			TOWN <u>LYNCH POINT</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3206 GRACE ROAD</u>			STREET ADDRESS (If rural give location) <u>3206 GRACE ROAD</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY BOKA SZALAI</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>OCT 20 19 55</u>		
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>FEB 13, 1879</u>
9. AGE last birthday: <u>76</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>HUNGARY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>JOSEPH BOKA</u>		14. MOTHER'S MAIDEN NAME: <u>DONT KNOW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.: <u>-</u>		17. INFORMANT & ADDRESS: <u>MRS. MARY YOWELL 3206 GRACE RD.</u>	

18. MEDICAL CERTIFICATION			Interval Between Onset And Death		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>Enterocytic fistula</u>			<u>1 week</u>		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Ovarian Carcinoma</u>			<u>at least 1 year.</u>		
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?	
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>October 20, 1955</u> , that I last saw the deceased alive on <u>October 18, 1955</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.					
SIGNATURE <u>David Owens</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>914 D Street Balto. 19</u> DATE SIGNED <u>10/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>OCT 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>BECAIR MEMO.</u> LOCATION (City, town, or county) (State) <u>BECAIR MD</u>	
DATE REGD BY LOCAL REGISTRAR <u>10/25/55</u>		REGISTRAR'S SIGNATURE <u>AW. Belcher</u>		24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u> ADDRESS <u>212 DUNDALK</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09561

9560

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<input checked="" type="checkbox"/> TOWN <u>Glyndon</u>		<u>4 yrs</u>		<u>Glyndon</u> <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Central Avenue</u>				STREET ADDRESS (If rural give location) <u>11 Central Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Charles Alexander Talbert</u>				<u>Oct 23 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>W</u>	<u>February 5 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired farmer</u>		<u>Farm manager</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Fletcher Talbert</u>				<u>Martha M Warfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Miss Florence Talbert Glyndon Md</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>						<u>3 wks.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive Cardio Vascular Disease</u>						<u>3 yrs.</u>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>none</u>		<u>none</u>					
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
<u>none</u>		<u>none</u>		<u>none</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
<u>none</u> M.		<u>none</u>		<u>none</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 13, 1950</u> to <u>Oct. 23, 1955</u> , that I last saw the deceased alive on <u>Oct. 22, 1955</u> and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>D. D. Caplan</u>		<u>M. D. Reisterstown, Md.</u>		<u>10-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 25 1955</u>		<u>St Thomas Cemetery</u>		<u>Owings Mills Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-24-55</u>		<u>Mary B. Eline</u>		<u>Wm Berryman & Sons</u>		<u>Reisterstown Md</u>	

BUREAU V. S.

OCT 28 1955

RECEIVED

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9386

CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK 22</u>		LENGTH OF STAY (in this place) <u>3 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7507 LAWRENCE Rd</u>				STREET ADDRESS (If rural give location) <u>7507 LAWRENCE Rd</u>			
3. NAME OF DECEASED: (First) <u>HARLEN</u> (Middle) <u>ARLINGTON</u> (Last) <u>TAULTON</u>				4. DATE OF DEATH: (Month) <u>10</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>SEPT. 20, 1905</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>STAMPER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>SOAP MFR.</u>		9. AGE last birthday: <u>50</u> yrs. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>				14. MOTHER'S MAIDEN NAME: <u>FANNY WEBER</u>			
13. FATHER'S NAME: <u>FRANK A. TAULTON</u>				17. INFORMANT & ADDRESS: <u>HELEN N. TAULTON - SAME.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY No.: <u>288-07-7678</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> Immediate cause (a) <u>CORONARY THROMBOSIS</u> DUE TO Antecedent causes (s) (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
Interval Between Onset And Death <u>1 YR.</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1, 1955</u> , to <u>Oct 21, 1955</u> , that I last saw the deceased alive on <u>Oct 18, 1955</u> , and that death occurred at <u>8:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Kefauver P. Brockmeyer M.D.</u>		(Degree or title)		ADDRESS <u>6714 Holmdel Ave</u>		DATE SIGNED <u>10/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>10-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>DAK LUTHERAN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 23-1955</u>		REGISTRAR'S SIGNATURE <u>William M Kelly</u>		24. FUNERAL DIRECTOR <u>Walter Bradley, Dundalk, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 25 1955
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9551

CERTIFICATE OF DEATH

09563

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>10 days</u>		TOWN <u>Baltimore</u>		<u>3Vo1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1618 W. Fayette Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LESTER TERRY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 24 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11/28/22</u>	9. AGE last birthday <u>32</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Vance County North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Terry</u>				14. MOTHER'S MAIDEN NAME <u>Flora Eaton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>VA Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
581.1 IMMEDIATE CAUSE (A) <u>LAENNEC'S CIRRHOSIS</u>						UNKNOWN	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MALNUTRITION, SEVERE</u>						UNKNOWN	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 13, 1955</u> , to <u>October 24, 1955</u> , that I saw the deceased alive on <u>October 13, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND</u>				ADDRESS (Street, city, town, state) <u>10-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Antioch Cemetery</u>		LOCATION (City, town, or county) (State) <u>Vance County, N. Carolina</u>	
24. REC'D BY REGISTRAR <u>Oct 26-55</u>		REGISTRAR'S SIGNATURE <u>Dawson E. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law Mortuary</u>		ADDRESS <u>802-04 Madison Ave., Baltimore 1, Md.</u>	

Shipped to: Garnes & Williams, Henderson, N., Carolina Ave., Baltimore 1, Md.

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF CLERK

21. SIGNATURE OF NOTARY

22. SIGNATURE OF JURY

23. SIGNATURE OF COURT

24. SIGNATURE OF STATE

25. SIGNATURE OF NATION

26. SIGNATURE OF WORLD

27. SIGNATURE OF UNIVERSE

28. SIGNATURE OF GOD

29. SIGNATURE OF HEAVEN

30. SIGNATURE OF EARTH

31. SIGNATURE OF WATER

32. SIGNATURE OF FIRE

33. SIGNATURE OF AIR

34. SIGNATURE OF LIGHT

35. SIGNATURE OF DARKNESS

36. SIGNATURE OF LIFE

37. SIGNATURE OF DEATH

38. SIGNATURE OF REBIRTH

39. SIGNATURE OF RESURRECTION

40. SIGNATURE OF JUDGMENT

41. SIGNATURE OF GLORY

42. SIGNATURE OF HONOR

43. SIGNATURE OF POWER

44. SIGNATURE OF WEALTH

45. SIGNATURE OF KNOWLEDGE

46. SIGNATURE OF WISDOM

47. SIGNATURE OF FAITH

48. SIGNATURE OF HOPE

49. SIGNATURE OF CHARITY

50. SIGNATURE OF LOVE

51. SIGNATURE OF MERCY

52. SIGNATURE OF GRACE

53. SIGNATURE OF PEACE

54. SIGNATURE OF JOY

55. SIGNATURE OF SORROW

56. SIGNATURE OF GRIEF

57. SIGNATURE OF PAIN

58. SIGNATURE OF SUFFERING

59. SIGNATURE OF TRIAL

60. SIGNATURE OF TEST

61. SIGNATURE OF PROOF

62. SIGNATURE OF EVIDENCE

63. SIGNATURE OF FACT

64. SIGNATURE OF TRUTH

65. SIGNATURE OF REALITY

66. SIGNATURE OF EXISTENCE

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73. SIGNATURE OF TRUST

74. SIGNATURE OF OBEY

75. SIGNATURE OF RESPECT

76. SIGNATURE OF REVERENCE

77. SIGNATURE OF ADMIRATION

78. SIGNATURE OF AWE

79. SIGNATURE OF WONDER

80. SIGNATURE OF AMAZEMENT

81. SIGNATURE OF ASTONISHMENT

82. SIGNATURE OF SURPRISE

83. SIGNATURE OF SHOCK

84. SIGNATURE OF STUNNING

85. SIGNATURE OF DASTARDLY

86. SIGNATURE OF CRUEL

87. SIGNATURE OF BARBARIC

88. SIGNATURE OF SAVAGE

89. SIGNATURE OF WICKED

90. SIGNATURE OF EVIL

91. SIGNATURE OF NECESSARY

92. SIGNATURE OF USEFUL

93. SIGNATURE OF IMPORTANT

94. SIGNATURE OF VALUABLE

95. SIGNATURE OF PRECIOUS

96. SIGNATURE OF RARE

97. SIGNATURE OF UNCOMMON

98. SIGNATURE OF EXTRAORDINARY

99. SIGNATURE OF REMARKABLE

100. SIGNATURE OF NOTABLE

101. SIGNATURE OF MEMORABLE

102. SIGNATURE OF EMINENT

103. SIGNATURE OF DISTINGUISHED

104. SIGNATURE OF PROMINENT

105. SIGNATURE OF CONSPICUOUS

106. SIGNATURE OF OBVIOUS

107. SIGNATURE OF APPARENT

108. SIGNATURE OF EVIDENT

109. SIGNATURE OF MANIFEST

110. SIGNATURE OF CLEAR

111. SIGNATURE OF OPEN

112. SIGNATURE OF PLAIN

113. SIGNATURE OF SIMPLE

114. SIGNATURE OF BASIC

115. SIGNATURE OF FUNDAMENTAL

116. SIGNATURE OF ELEMENTARY

117. SIGNATURE OF PRIMITIVE

118. SIGNATURE OF ORIGINAL

119. SIGNATURE OF FIRST

120. SIGNATURE OF INITIAL

121. SIGNATURE OF BEGINNING

122. SIGNATURE OF START

123. SIGNATURE OF COMMENCEMENT

124. SIGNATURE OF ONSET

125. SIGNATURE OF OUTSET

126. SIGNATURE OF BEGINNING

127. SIGNATURE OF START

128. SIGNATURE OF COMMENCEMENT

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280. SIGNATURE OF OUTSET

281. SIGNATURE OF BEGINNING

282. SIGNATURE OF START

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9562

CERTIFICATE OF DEATH

09564

Reg. Dist. No. 39

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Monkton</i>	<i>74 yrs</i>	TOWN <i>Phoenix</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>Corbett Rd</i>		<i>Carroll Rd.</i>	<i>1</i>
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Louis</i> (Middle) <i>Gartfield</i> (Last) <i>Thomas</i>		(Month) <i>October</i> (Day) <i>22</i> (Year) <i>1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>Colored</i>	<i>Widowed</i>	<i>11 Sept. 1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Farmer Laborer</i>			<i>Rayville, Balto Co. Md.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John Thomas</i>		<i>Fenrietta Bosley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<i>NO</i>		<i>215-34-1454</i>	<i>Ethel Lillian Thomas, Phoenix, Md</i>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>			<i>few minutes</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Arteriosclerosis</i>			<i>over 7 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work Not while at work	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Jan 48</i> , to <i>Oct 22</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>17 Oct</i> , 19 <i>55</i> , and that death occurred at <i>12:35 P</i> .M, from the causes and on the date stated above.			
SIGNATURE <i>Walter T. Lees</i>		DATE SIGNED <i>22 Oct 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>St. Lukes Methodist Herford, Balto Co. Md.</i>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <i>M. Elizabeth Gorsuch</i>		<i>J. Scott Brooks, Sparks, Md.</i>	
DATE <i>Oct 22, 1955</i>		ADDRESS (Street, city, town, state)	

9396

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Halethorpe</u>	LENGTH OF STAY (in this place) <u>3 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis Junction</u>	(If rural give location) <u>R.F.D.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1906 North Eastern</u>		STREET ADDRESS <u>13X-2</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>SAMUEL</u>	(Middle) <u>S</u>	(Last) <u>JIMMONS</u>	DATE OF DEATH: <u>Oct 11</u> 19 <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Oct 31 1870</u>
9. AGE last birthday <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>messenger in Government</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Grace B. Keegan</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>442X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cardiovascular disease</u>			
(B) <u>Arteriosclerosis, Hypertension</u>			
(C) <u>Edema</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 24 1955</u> to <u>October 11 55</u> that I last saw the deceased alive on <u>Oct 10</u> , 1953, and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Oct 11 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lawrence</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 14 55</u>		LOCATION (City, town, or county) (State) <u>Tesseyo Md</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Ridgely Selby</u>	
		ADDRESS <u>401 Wash Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955

George Jones Jones
George Jones Jones
George Jones Jones

BUREAU V. S.

OCT 17 1955

RECEIVED
JAN 20 1956
BUREAU OF RECORDS

RECEIVED
OCT 17 1955

RECEIVED
OCT 17 1955

MARYLAND

9563

CERTIFICATE OF DEATH

09566
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1103 HARWALL RD.</u>		STREET ADDRESS (If rural, give location) <u>1103 HARWALL RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>J.</u> (Middle) <u>LESTER</u> (Last) <u>TOPPER</u>	4. DATE OF DEATH (Month) <u>OCT.</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-23-1894</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE MANAGER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JACOB TOPPER</u>		14. MOTHER'S MAIDEN NAME <u>ADALIDE WACERMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr. Lester Topper - 1103 Harwall Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>151X Inoperable Carcinoma of Stomach.</u>		<u>9 months</u>	
Antecedent cause(s) <u>Division</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1, 1955</u> , to <u>10/17, 1955</u> , that I last saw the deceased alive on <u>10/14/55</u> , and that death occurred at <u>8:35 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>F. Ford Loker, M.D.</u>		DATE SIGNED <u>10/19/55</u> (1955)	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>10-20-55</u>	NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>	LOCATION (City, town, or county) <u>Balto.</u>
DATE REC'D BY LOCAL REG. <u>10/19/55</u>	REGISTRAR'S SIGNATURE <u>J. E. Barry</u>	24. FUNERAL DIRECTOR ADDRESS <u>Funeral Home Catonsville, Md.</u>	

RECEIVED

OCT 20 1955

BUREAU V. S.

9564

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>52 Catonsville</i>	LENGTH OF STAY (in this place) <i>14 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Severna Park.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove Hospital</i>	STREET ADDRESS (If rural give location) <i>02X-2</i>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>FRANK</i>	(Middle) <i>A</i>	(Last) <i>VINTON</i>	OF DEATH: <i>10 4 1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Sept. 20, 1870</i>
9. AGE last birthday <i>85</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Printer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Publisher</i>	11. BIRTHPLACE (State or foreign country): <i>Md.</i>
13. FATHER'S NAME: <i>Thomas Vinton</i>		14. MOTHER'S MAIDEN NAME: <i>Rebecca Robinson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-18-1794</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Emma E. Vinton - Severna Park, Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>450.0 Generalized Arteriosclerosis</i>			
ANTECEDENT CAUSE (B) <i>Dehydration & Malnutrition</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Renal Failure.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>9/20/55</i> , to <i>10/4/55</i> , that I last saw the deceased alive on <i>10/4/55</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>SPRING GROVE HOSPITAL</i>		ADDRESS <i>H. Brown, Jr.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10/7/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>10-6-55</i>		REGISTRAR'S SIGNATURE <i>H. Brown, Jr.</i>	
24. FUNERAL DIRECTOR <i>Wm. J. Lickner & Sons - Balto 17</i>		ADDRESS <i>Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN Ruston
 HOSPITAL OR INSTITUTION OR Maternal Motherhouse
 STREET ADDRESS 1100 Boyce Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Pennsylvania COUNTY Allegheny
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Steeleton 75X-3
 STREET ADDRESS 132 Lincoln Street
 (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CAROLINEC.WAGENBACH

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

Oct.271955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

FemaleWhiteSingleJune 24, 188679 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Ernest S. WagenbachHenrietta P.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

nonoSister Martha 1100 Boyce Ave.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Hyperbensive - cardio-vascular disease

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 1939, to 10-27, 1955, that I last saw the deceasedalive on 10-26, 1955, and that death occurred at 7:05 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR.

ADDRESS

10-27-55Nov. 1, 1955Steeleton PaSteeleton PaJ. B. Wippert1300 Putnam Place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Hypocistis - Carlin Pass
Chimney

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10.55 22

36 Fork Creek
10.55.22

10.56 22
D. L. West
m. D.

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CERTIFICATE OF DEATH

Reg. Dist. No. 33-

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Glen Rock</u>	LENGTH OF STAY (in this place) <u>72 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Glen Rock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stiltz.</u>		STREET ADDRESS (If rural give location) <u>Stiltz.</u>	

3. NAME OF DECEASED: (Type or Print)	(First) <u>Charles</u>	(Middle) <u>H.</u>	(Last) <u>Walker.</u>	4. DATE (Month) (Day) (Year) OF DEATH: <u>October 22, 1955.</u>
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5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 17, 1882</u>	9. AGE last birthday <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm.</u>	11. BIRTHPLACE (State or foreign country): <u>Glen Rock, Pa. R.D.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13. FATHER'S NAME: <u>Daniel Walker.</u>	14. MOTHER'S MAIDEN NAME: <u>Susan Nace.</u>
--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <u>No</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT & ADDRESS: <u>Mrs. Cora Walker, Glen Rock, Pa.</u>
---	---------------------------------	--

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) <u>Acute Myocarditis</u>	<u>8 mos.</u>
ANTECEDENT CAUSE (S)	DUE TO <u>Coronary Thrombosis</u>	<u>Immediate death</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.	(B) <u></u>	
	DUE TO <u></u>	
	(C) <u></u>	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
--

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Mar, 1953, to Oct 22, 1955, that I last saw the deceased alive on Oct. 18, 1955, and that death occurred at 7:00A.M., from the causes and on the date stated above.

SIGNATURE O. W. Summit M. D. ADDRESS Codomo, Pa. DATE SIGNED Oct. 22, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct. 25, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Stiltz Cemetery</u>	LOCATION (City, town, or county) (State) <u>Glen Rock, Pa. R.D. 3.</u>
DATE REC'D BY LOCAL REGISTRAR <u>10/25/55</u>	REGISTRAR'S SIGNATURE <u>Charles L. Friedman</u>	24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>	ADDRESS <u>New Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 1 1955

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

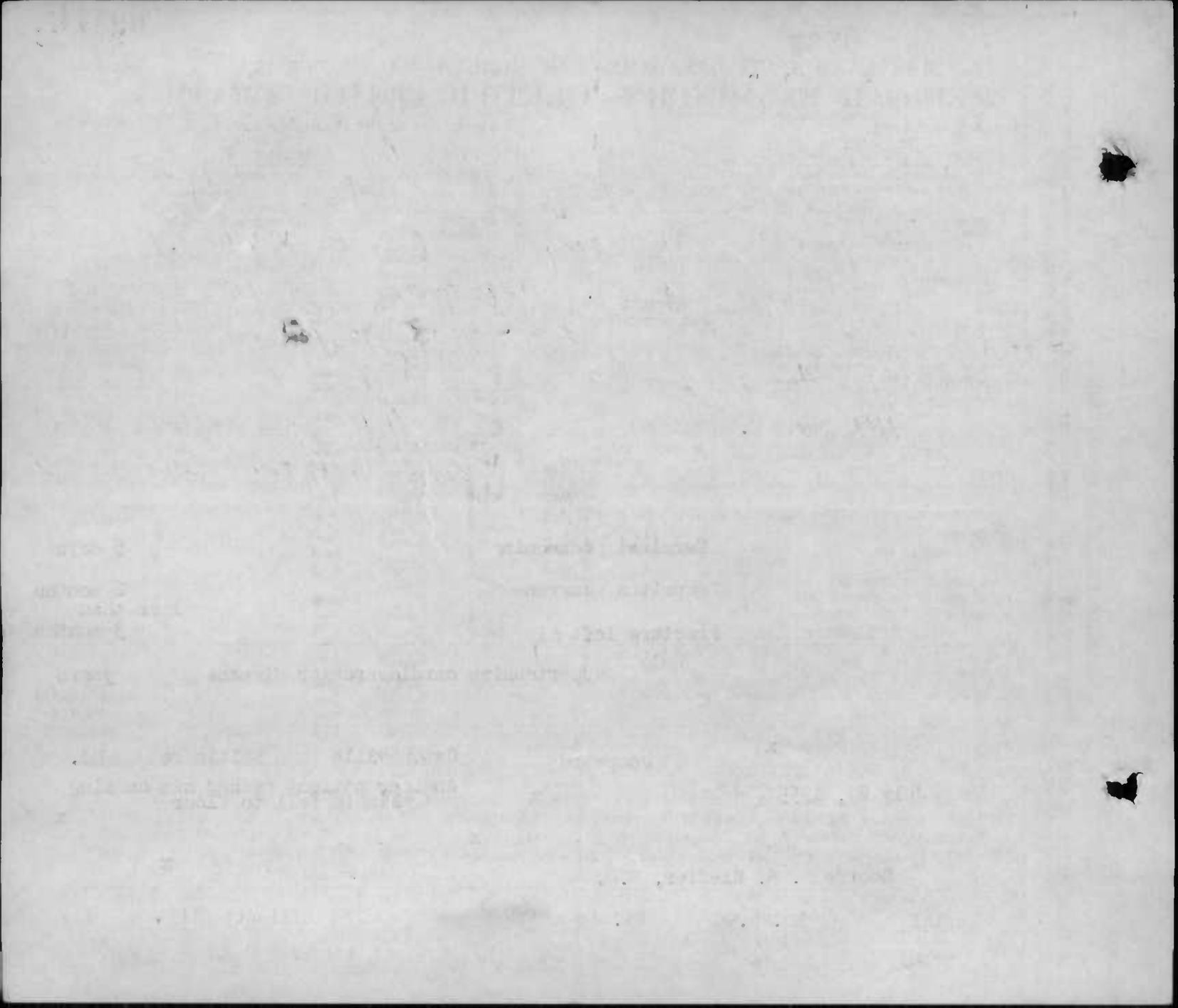
No. 30

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		MARYLAND	STATE	MD. COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Catonsville		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	Linthicum Hts 02X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Spring Grove State Hosp		STREET ADDRESS	(If rural, give location) 206 E Maple Rd.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	Harvey	O'Neill	Webster Jr.	10-23	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
M	W		2-14-1883	72 72 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
accountant Ins. Agent	Life Insurance		MD		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
UNK David P. Webster			UNK Martha Washington Shores		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no				Sophia Webster - Same as # 2	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
936.7 Immediate cause (a) Terminal pneumonia DUE TO				5 days
Antecedent cause(s) (b) Decumitus gangrene DUE TO				2 months less than
(c) Fracture left hip				3 months
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				years
Hypertensive cardiovascular disease				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	(State)
Catonsville		Baltimore	MD.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
July 29, 1955 5-30 A.M.		21f. HOW DID INJURY OCCUR? Another patient pushed him causing him to fall to floor		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED
George S. M. Kieffer, M.D.		DEPUTY MEDICAL EXAMINER		
M.D.		ASSISTANT MEDICAL EXAM.		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	10.26.55	St. Johns	Ellicott City.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
10/31/55	D. W. Hedrick	Wm. J. Tietzner & Sons, Balto 17 Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>4 Hrs. 40 M.</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1800 Barclay Street</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES F. WELSH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 28 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-2-94</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Welsh</u>				14. MOTHER'S MAIDEN NAME <u>Mary McCauley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-18-7976</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>541.0 DUODENAL ULCER WITH HEMORRHAGE</u>						<u>24 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 28 5:30 PM</u> to <u>Oct. 28 10:10 PM</u> , 19 <u>55</u> , and that death occurred at <u>10:10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur G. Edwards</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
DATE <u>10-29-55</u>				DATE SIGNED <u>10-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Rawson L. Parker</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Forace, Inc.</u>		ADDRESS <u>712-14 E. North Ave. Baltimore, Maryland</u>	

CERTIFICATE OF DEATH

0528

See Form No.

1. Usual Residence (House or Apartment)

2. Date of Death

3. Time of Death

4. Place of Death

5. Cause of Death

6. Nature of Injury

7. Name of Physician

8. Name of Hospital

9. Name of Nurse

10. Name of Undertaker

11. Name of Coroner

12. Name of Registrar

13. Name of Burial Place

14. Name of Cemetery

15. Name of Interment

16. Name of Burial

17. Name of Burial

18. Name of Burial

19. Name of Burial

20. Name of Burial

21. Name of Burial

22. Name of Burial

23. Name of Burial

24. Name of Burial

25. Name of Burial

26. Name of Burial

27. Name of Burial

28. Name of Burial

29. Name of Burial

1. Name of Deceased

2. Date of Birth

3. Sex

4. Race

5. Religion

6. Education

7. Occupation

8. Marital Status

9. Date of Marriage

10. Date of Divorce

11. Date of Widowhood

12. Date of Death

13. Date of Burial

14. Date of Interment

15. Date of Burial

16. Date of Burial

17. Date of Burial

18. Date of Burial

19. Date of Burial

20. Date of Burial

21. Date of Burial

22. Date of Burial

23. Date of Burial

24. Date of Burial

25. Date of Burial

26. Date of Burial

27. Date of Burial

28. Date of Burial

29. Date of Burial

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BUREAU V. S.

001 31 1955

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Md.</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55 Towson</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> <u>55</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70 912 Dulaney Court Apt's</u>			STREET ADDRESS (If rural give location) <u>912 Dulaney Court Apt's</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
DECEASED: (Type or Print) <u>Mary G. Welsh</u>			OF DEATH: <u>Oct. 22, 19 55</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>Oct. 27, 1885</u>		
9. AGE last birthday <u>69</u> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		
11. BIRTHPLACE (State or foreign country): <u>Belfast Ireland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>William Hamilton</u>			14. MOTHER'S MAIDEN NAME: <u>Catherine Gunn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>1701 PENNIA. AVE</u>		
17. INFORMANT & ADDRESS: <u>Mrs. Rob't F. Strangmann 7101 Bristol Rd</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>420.1 Coronary artery occlusion</u>		<u>Uncertain</u>
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	---	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from <u>SEPT 18, 1955</u> , to <u>OCT 22, 1955</u> , that I last saw the deceased alive on <u>SEPT 21, 1955</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above.	
SIGNATURE <u>Madonna C. Sawinski</u>	DATE SIGNED <u>OCT 24, 1955</u>
M. D. <u>1701 PENNIA. AVE</u>	

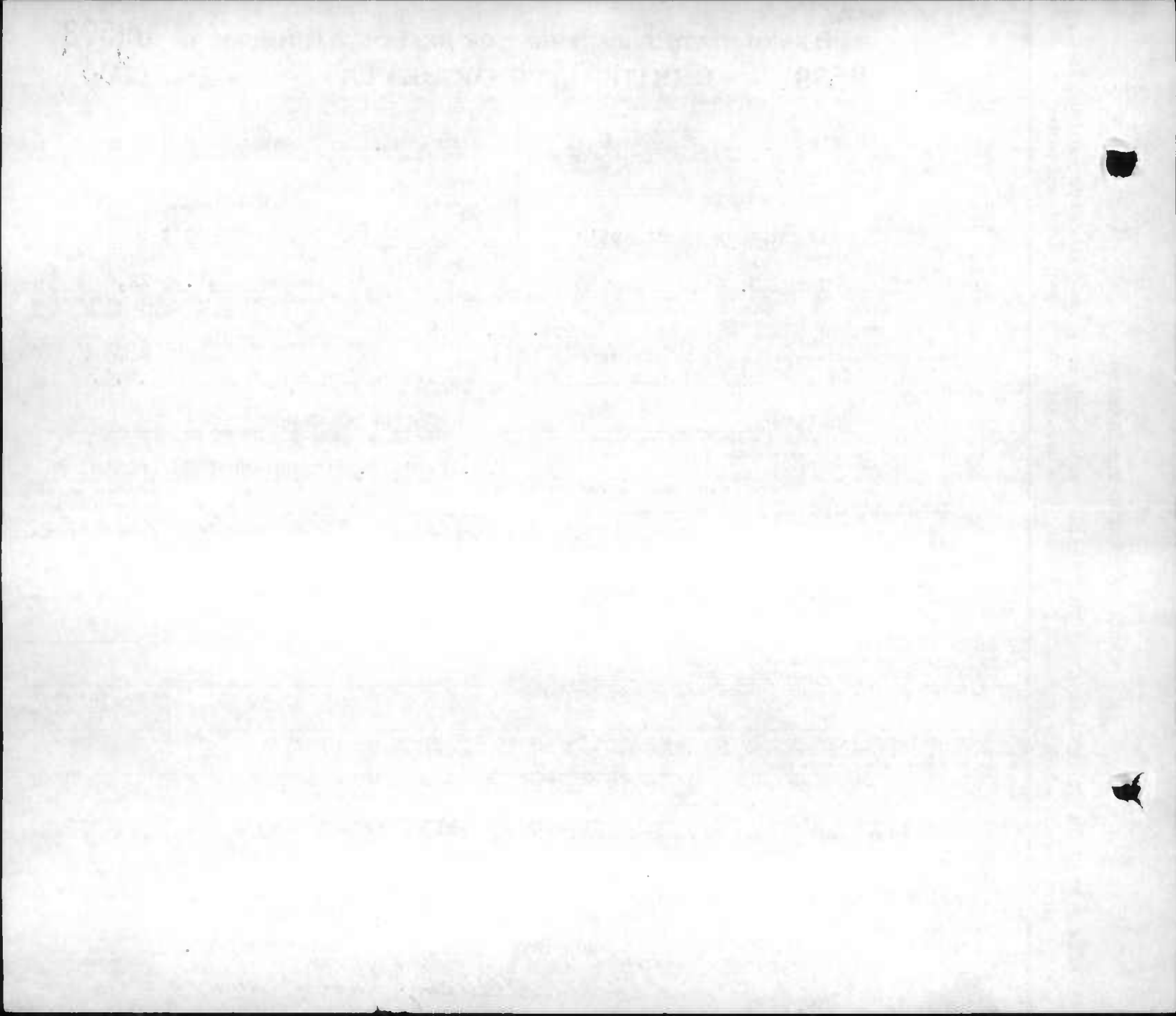
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 23 1955</u>	<u>Loudon Park</u>	<u>Baltimore, Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>10/24/55</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR ADDRESS <u>William J. Zeleny + Sons North + Penna Aves</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9570

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard		LENGTH OF STAY (in this place) 2 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 1902 Tolson Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last) LAWRENCE E. WENKER		4. DATE OF DEATH: (Month) (Day) (Year) October 9, 1955					
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 7/10/02	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard		10B. KIND OF BUSINESS OR INDUSTRY: Store		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Wenker				14. MOTHER'S MAIDEN NAME: Fredericka Stegman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): Yes (If Yes, give war or dates of service) Korean		16. SOCIAL SECURITY NO. 705-10-4154		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CARCINOMA OF RECTUM						2 YEARS	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2-55 (after)		19B. MAJOR FINDINGS OF OPERATION with colostomy Abdomino-perineal resection at Baltimore City Hospital				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 7, 1955 , to Oct. 9, 1955 , and that death occurred at 1:35 PM , from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIET, M.D.				ADDRESS M. D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 10-10-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF OCT. 12, 1955		NAME OF CEMETERY OR CREMATORY Saint Stanislaus Cemetery		LOCATION (City, town, or county) (State) Baltimore (Dundalk), Md.	
DATE REC'D BY LOCAL REGISTRAR 10-11-55		REGISTRAR'S SIGNATURE J. W. Hedrick		24. FUNERAL DIRECTOR Wm. Cook-Blight, Inc.		ADDRESS 6009 Harford Rd. Baltimore 14, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-44

RECEIVED
JAN 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-44)
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09575

9571

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u> LENGTH OF STAY (in this place) <u>80 yrs</u>		TOWN <u>Baltimore</u> 3V014	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>423 N. Milton Ave.</u>	
3. NAME OF DECEASED (Type or Print) ASIA MINA WERNER		4. DATE OF DEATH (Month) (Day) (Year) October 23, 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH Oct. 15, 1865
9. AGE last birthday 90 yrs.		10. BIRTHPLACE (State or foreign country) Farwell - Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis C. Ingram		14. MOTHER'S MAIDEN NAME ? Marston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Mr. George Werner, 423 N. Milton Ave.		18. MEDICAL CERTIFICATION Baltimore 24 Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Coronary atherosclerosis with myocardial infarction

(c)

Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 19, 1955 to Oct. 23, 1955, that I last saw the deceasedalive on Oct. 20, 1955, and that death occurred at 5:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

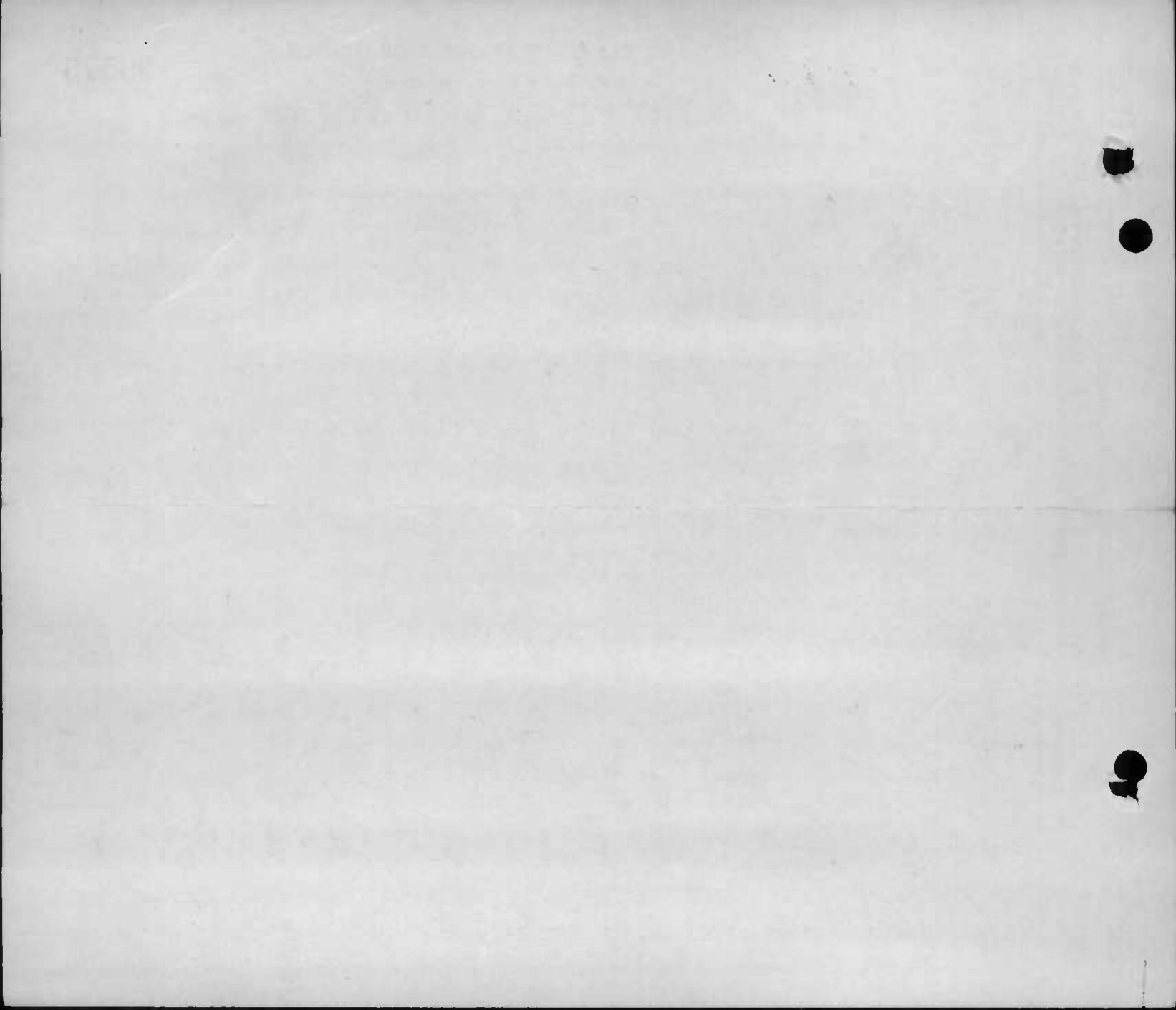
23. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>Oct. 26, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>10/25/55</u>	REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.		ADDRESS <u>Baltimore Md.</u>

Sey P. Sander

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9572

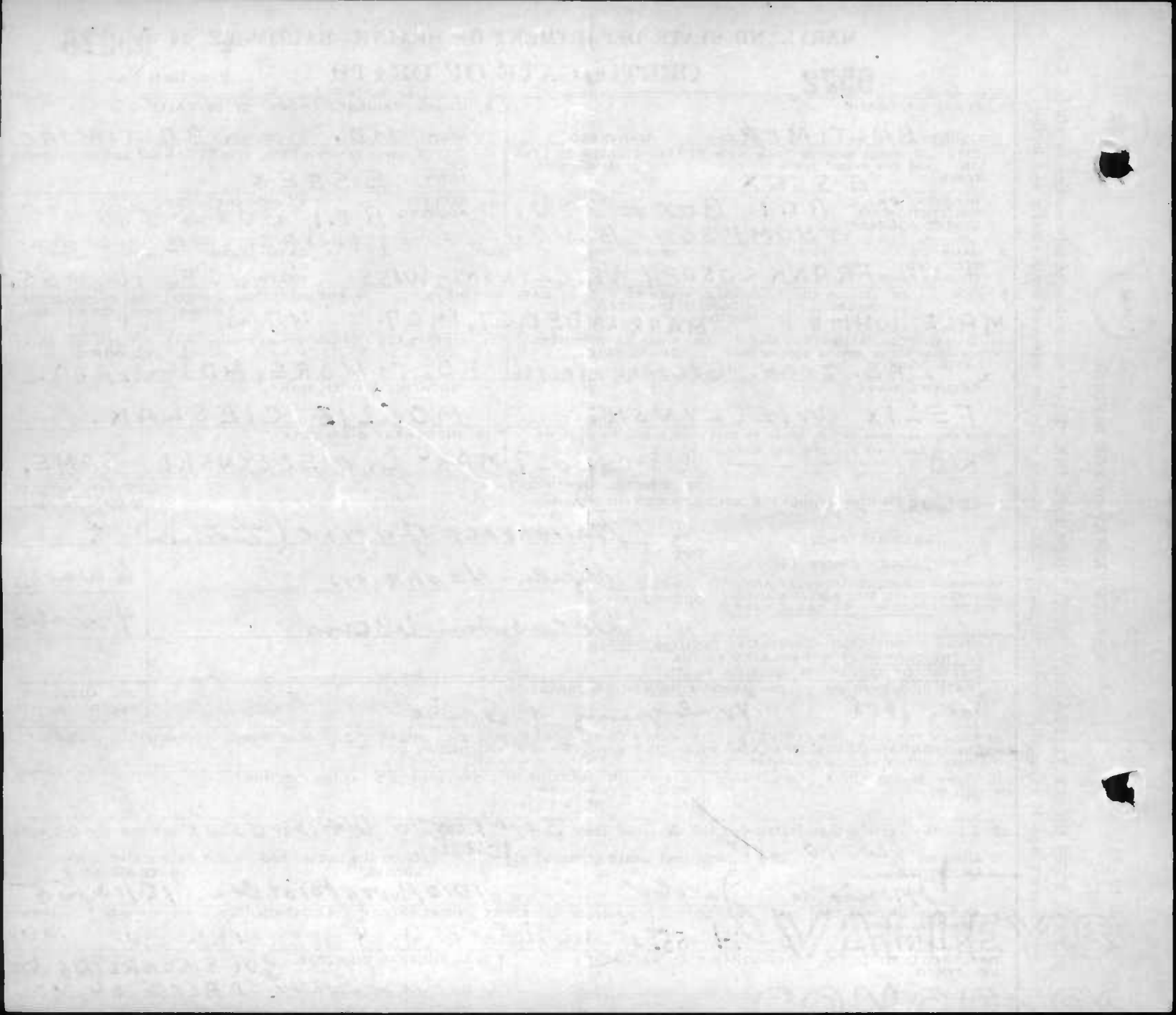
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RT. 1 BOX # 380 THOMPSON BLVD.</u>				STREET ADDRESS (If rural give location) <u>RT. 1 BOX # 380 THOMPSON BLVD.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FRANK JOSEPH WIECZYNSKI-WISE</u>				4. DATE (Month) (Day) (Year) <u>OCT. 10, 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>DEC. 27, 1907.</u>	9. AGE last birthday <u>47</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAB. TECH. GENERAL ELECTRIC</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>FELIX WIECZYNSKI</u>				14. MOTHER'S MAIDEN NAME: <u>MOLLIE CIESLAK.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-05-5327</u>		17. INFORMANT & ADDRESS: <u>MARY C. WIECZYNSKI SAME,</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Malignancy of Spine (adenocarcinoma)</u>						<u>2</u>	
ANTECEDENT CAUSE (S): (B) <u>Pyelo-Nephritis</u>						<u>6 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Decubitus Ulcers</u>						<u>4 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>July 1955</u>				19B. MAJOR FINDINGS OF OPERATION <u>Malignancy of Spine</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1, 1955</u> , to <u>Oct 10, 1955</u> that I last saw the deceased alive on <u>Oct 10, 1955</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Monis G. Jacoby</u>		ADDRESS <u>M. D. 1010 NORTH POINT RD.</u>		DATE SIGNED <u>10/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY</u>		LOCATION (City, town, or county) (State) <u>GERMAN HILL RD. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>G. W. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Charles S. Gierler</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9573
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Sorensen Nursing Home	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 7912 Ruxway Rd. 4		STREET ADDRESS (If rural give location) 6523 Langdale Rd. #6	
3. NAME OF DECEASED: (First) (Middle) (Last) MARY VIRGINIA WILLIAMS		4. DATE (Month) (Day) (Year) OF DEATH: Oct. 3, 19 55	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Feb. 24, 1879
9. AGE last birthday: 76 yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rtd Housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	
11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: -- Crispens		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Mr. Elmer H. Packie, Jr.-6523 Langdale Rd.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) 422.1 with dilation myocardial Hypertrophy		2 days
ANTECEDENT CAUSE (S) (B) myocarditis chronic		10 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) General Arteriosclerosis.		10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept 24, 1955**, to **Oct. 3, 1955**, that I last saw the deceased alive on **Oct. 2, 1955**, and that death occurred at **8.00 P.M.** from the causes and on the date stated above.

SIGNATURE **J. J. Graham Manton** ADDRESS **M. D. 516 Cathedral St** DATE SIGNED **10-5-1955**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 10/6/55	NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	LOCATION (City, town, or county) (State) Balto., Md.
---	--------------------------------	--	--

DATE REC'D BY LOCAL REGISTRAR 10-5-55	REGISTRAR'S SIGNATURE Dr. J. J. Graham Manton	24. FUNERAL DIRECTOR Wm. J. Schuler & Son	ADDRESS Baltimore, Md.
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09578

9574

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Fort Howard</u>		<u>30 Days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>912 Shuter Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>GEORGE</u>		(Middle) <u>G.</u>		(Last) <u>WILSON</u>		<u>October 26</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6/13/11</u>	9. AGE last birthday <u>41</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George L. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Virginia MN: Madison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>212-12-7580</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
286.6 IMMEDIATE CAUSE (A) <u>CACHEXIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u>	
ANTECEDENT CAUSE(S) DUE TO <u>DIETARY INSUFFICIENCY (?)</u>						<u>SEV. YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>UNDERLYING CAUSE LAST.</u>							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 26</u> , 19 <u>55</u> , to <u>Oct. 26</u> , 19 <u>55</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE TIME OF <u>10/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>06/29/55</u>		REGISTRAR'S SIGNATURE <u>Sawran L Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Lee</u> ADDRESS <u>Mortuary, 802-04 Madison Ave. Baltimore 1, Maryland</u>			

Group **S.E.**

NOV 2 1955

RECEIVED

9575

CERTIFICATE OF DEATH

Reg. Dist. No.

y. The

1. NAME OF DECEASED (Type or Print) Harry Repp Worman			2. DATE OF DEATH Oct. 19, 1955		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION 2519 Cedar Drive			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2519 Cedar Drive			E. LENGTH OF STAY IN BALTIMORE 50 yrs.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 13, 1882	9. AGE (In years, last birthday) 73	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10B. KIND OF BUSINESS OR INDUSTRY Otis Elevator Co.		
11. BIRTHPLACE (State or foreign country) Frederick, Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George Moses Worman			14. MOTHER'S MAIDEN NAME Amanda Jane Repp		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-03-0410		
17. INFORMANT H. Richard Worman			ADDRESS - 2519 Cedar Drive.		
18. 141X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypostatic Pneumonia CAUSE OF DEATH Ca of Tongue C Metastasis INTERVAL BETWEEN ONSET AND DEATH 2 de					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 9/20 , 19 55 , to 10/19 , 19 55 , that I last saw the deceased alive on 10/19 , 19 55 , and that death occurred at 5 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Joseph S. Lawkatis			23B. ADDRESS 679 Washington Blvd		
23C. DATE SIGNED 10/19/55					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/22/1955		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Frederick, Md.		25. FUNERAL DIRECTOR Edmund C. Cunniff		ADDRESS 10-20-55	

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9576

09580

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		STATE	Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN	Catonsville 28	1 yr 8 days	TOWN	Annapolis 02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Spring Grove State Hospital		STREET ADDRESS	(If rural, give location) RFD #1	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	Brice	John	WORTHINGTON	October 22,	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	White	Married	Apr. 17, 1864	91 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Carpenter & Farmer				Maryland	U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
B. John Worthington			Mathilda Pue		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
			17. INFORMANT & ADDRESS:		
			Records: Spring Grove State Hospital		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
902.7 Immediate cause	(a) Terminal bronchopneumonia	1 week
Antecedent cause(s)	(b) Senility	?
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(c) Fracture left femur	3 weeks

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Hospward	21c. (City or town) (County) (State) Catonsville Baltimore Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/1/55 ? M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell from bed 3K

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *Geo. S. M. Kieffer, M.D.* 1010 Linden
 CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 10/22/55
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	10/24/55	St Pauls	Crownsville	MD.
DATE REC'D BY LOCAL REG.	OCT. 24	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		<i>John M. Taylor + Sons</i>	Annapolis, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09581

Reg. Dist.

No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>WOODLAWN</u>				TOWN <u>6900 CARL AVE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6900 CARL AVE</u>				STREET ADDRESS (If rural, give location) <u>WOODLAWN, MD.</u>			
3. NAME OF DECEASED: (First) <u>JOSEPH</u>		(Middle) <u>G.</u>		(Last) <u>YAEGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 29 19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 27, 1903</u>		9. AGE last birthday: <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>POULTRY RAISER- POULTRY-S.E.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>GEORGE J. YAEGER</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZ. M. SCHWARTZKOPF</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. J. S. Yaeger, 6900 Carl Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Cornmeal Thrombosis</u>							
DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Leo M. Kieffer</u>		1010 Leach Ave.		CHIEF MEDICAL EXAMINER		DATE SIGNED <u>10/31/55</u>	
DEPUTY MEDICAL EXAMINER		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF <u>11-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-1-55</u>		REGISTRAR'S SIGNATURE <u>August C. Bonnell</u>		24. FUNERAL DIRECTOR <u>Funeral Home. Catonsville, Md.</u>		ADDRESS	

RECEIVED
BUREAU V. 2
NOV 3 1965

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

[The body of the letter contains several paragraphs of text that are mostly illegible due to fading and bleed-through from the reverse side. The text appears to be a standard memorandum format.]

RECEIVED
BUREAU V. 2
NOV 3 1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 149582
9578 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN Catonsville		18yr2mos17days		TOWN Baltimore 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural give location) 2448 West North Avenue			
3. NAME OF DECEASED: (First) Anna		(Middle) Giannone		(Last) Yakel		4. DATE (Month) (Day) (Year) OF DEATH: October 3, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 3-10-1899		9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jack Morrison				14. MOTHER'S MAIDEN NAME: Amanda Morrison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)			16. SOCIAL SECURITY No. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of Cervix with metastases							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1- , 19 55 to 10-3- , 19 55 that I last saw the deceased alive on 10-3- , 19 55 , and that death occurred at 2:00P M, from the causes and on the date stated above.							
SIGNATURE Stella Wachler				DATE SIGNED 10-3-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/5/55		NAME OF CEMETERY OR CREMATORY Cathedral		LOCATION (City, town, or county) (State) Balt., Md.	
DATE REC'D BY LOCAL REGISTRAR 10/4/55		REGISTRAR'S SIGNATURE V.E. Harvey		24. FUNERAL DIRECTOR Mac Nabholz		ADDRESS 28	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09583

9579

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Parkville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 2941 Manns Ave.				STREET ADDRESS (If rural give location) 2941 Manns Ave.			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) VIOLA		(Middle) AGNES		(Last) ZIMMERMAN		DATE: Oct. 4, 19 55	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Dec. 4, 1884	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk			10B. KIND OF BUSINESS OR INDUSTRY: Motor Registration		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John William Harvey Burgoon				14. MOTHER'S MAIDEN NAME: Emma Virginia Frock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mr. Leo A. Zimmerman - 2941 Manns Ave.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 155X IMMEDIATE CAUSE (A) Carcinomatous DUE TO ANTECEDENT CAUSE (S) (B) Primary origin Gallbladder DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF "INJURY" M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/7/55 , to 10/7/55 , that I last saw the deceased alive on 10/6/55 , and that death occurred at 7 P. M. from the causes and on the date stated above. SIGNATURE Frank E. Karik, Jr. ADDRESS 9005 Harford Rd DATE SIGNED 10/6/55 M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/7/55		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE REC'D BY LOCAL REGISTRAR 10-6-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Mr. J. Dickerson & Sons - Balto		ADDRESS 17	

